DOCUMENT RESUME

ED 265 713 EC 181 703

AUTHOR Jones, Renai
TITLE The Development of Speech Workshops and Videotape Library to Train Teachers and Parents of Exceptional Infants and Preschoolers.
PUB DATE 85
NOTE 155p.; Ed.D. Practicum Report, Nova University.
PUB TYPE Dissertations/Theses - Practicum Papers (043) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS *Communication Skills; *Developmental Disabilities; Infants; *Language Acquisition; *Parent Education; Parent Role; Program Effectiveness; *Receptive Language; *Speech Therapy; Teacher Role; Videotape Recordings; Workshops; Young Children

ABSTRACT

The practicum focused on the lack of sufficient speech therapy for 90 physically and mentally handicapped infants and preschoolers in a program for developmentally delayed children. Two workshops were conducted and a speech videotape library was established consisting of demonstrations of 49 receptive language goals in developmental order. Videos illustrated how parents or therapists carry out speech goals. Fifteen children, teachers, and parents comprised the evaluation sample. Results from questionnaires, observations/interactional analyses, developmental tests, recording forms, and videotape circulation forms indicated that 100% of the parents and teachers used the tapes, 100% learned how to carry out goals, 100% learned which goals came next developmentally, and 50% of the parents and teachers learned how to simplify goals. In addition, there was a 17% increase in use of proper reinforcers, and 100% of the children progressed in the area of receptive language. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED265713

PRACTICUM REPORT

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

Center for the
Advancement of Education
Ed.D. Program

The Development of Speech Workshops and Videotape Library to Train Teachers and Parents of Exceptional Infants and Preschoolers

3301 College Avenue
Fort Lauderdale, Florida 33314
305/475-7300

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Renai Jones

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC 18170 3

NOVA UNIVERSITY

The Development of Speech Workshops and Videotape Library to Train Teachers and Parents of Exceptional Infants and Preschoolers

by

Renai Jonas

Cluster 13

A Practicum Report Presented to the
Ed.D. Program in Early Childhood in
Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1985

PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier:

Pat Montesino
Name
Program Coordinator
Title
1201 Australian Avenue
Riviera Beach, FL 33404
Address

May 31, 1985
Date

This practicum report was submitted by Renai Jonas under the direction of the reviewer listed below. It was submitted to the Ed.D. Program in Early Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education in Early Childhood at Nova University.

Approved:

6/26/85
Date of Final Approval of Report

JoEllen Salce Rogers
JoEllen Salce Rogers, Ph.D.

Acknowledgements

An appreciation of thanks is given to all those family members, friends and colleagues who were instrumental in the development, implementation, and final product of the Speech Videotape Library.

This is just the beginning...

TABLE OF CONTENTS

TITLE PAGE..... i

APPROVAL PAGE..... ii

ACKNOWLEDGEMENTS..... iii

TABLE OF CONTENTS..... iv

LIST OF TABLES..... vi

ABSTRACT..... vii

Chapter..... 1

I INTRODUCTION..... 1

Description of Community 1
Author's Work Setting and Role 3

II STUDY OF THE PROBLEM 12

Problem Description..... 12
Problem Documentation 17
Causative Analysis..... 20
The Related Literature 26

III ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS 40

Statement of General Goals..... 40
Behavioral Expectations..... 44
Evaluation Instruments..... 48

IV SOLUTION STRATEGY..... 58
Discussion and Evaluation of Solutions... 58
Description and Selected Solutions..... 65
Report of Action Taken..... 76

V RESULTS, CONCLUSIONS AND RECOMMENDATIONS..... 86
Results/Discussion..... 86
Conclusions..... 99
Recommendations..... 102
Dissemination..... 104

REFERENCES..... 105

APPENDICES..... 113

APPENDIX A: Interactional Analysis Chart..... 114
APPENDIX B: Videotape Library Circulation Form 116
APPENDIX C: Questionnaire..... 118
APPENDIX D: Definition of Terms..... 120
APPENDIX E: Recording Form..... 123
APPENDIX F: Receptive Language Develoment..... 125
APPENDIX G: Outline of Workshop I..... 128
APPENDIX H: Outline of Workshop II..... 130
APPENDIX I: Invitation to Workshop..... 132
APPENDIX J: Letter to Principal..... 134
APPENDIX K: List of Goals of Videotape..... 136
APPENDIX L: Timetable..... 139
APPENDIX M: Parental Permission Slip..... 140
APPENDIX N: Letter to Parents..... 142

LIST OF TABLES

Table		Page
I	Goals/Criteria/Results.....	41
II	Test Results.....	52
III	Interactional Analysis Results.....	56

Abstract

The Development of Speech Workshops and Videotape Library to Train Teachers and Parents of Exceptional Infants and Preschoolers.
Jonas, Renai, 1985: Practicum Report, Nova University Ed. D. Early Childhood Education Program
Descriptors: Early Childhood/Infancy/Neurological Impairments/Physically Handicapped/Speech Education/Speech Handicaps/Speech Therapy.

This practicum addressed the lack of sufficient speech therapy for 90 physically and mentally handicapped infants and preschoolers in an infant intervention and preschool program. The goals were as follows: parents and teachers will learn to carryout speech goals; they will learn to simplify a speech goal and determine which goal proceeds the one that was accomplished; parents and teachers will learn how to reinforce appropriate behaviors; children will receive more therapy; children will progress in the area of receptive language and teachers; parents, teachers and children will become motivated to learn.

In order to resolve this problem, the author implemented two workshops in four preschools and developed a speech videotape library for teachers and parents to view. The videotape library consisted of demonstrations of 49 receptive language goals (in developmental order). The video shows how a parent or therapist carries out a speech goal.

A sample of 15 children, teachers, and parents were utilized. Results from a questionnaire, observations/interactional analysis, developmental tests, recording forms, and videotape circulation forms indicated that 100% of the parents and teachers utilized the tapes, 100% learned how to carryout goals, 100% learned which goal came next developmentally and 50% of the parents and teachers learned how to simplify goals. All participants became motivated to learn. There was a 17% increase in proper reinforcers used and 100% of the children progressed in the area of receptive language. Ninety-three percent progressed at least four months during five months of implementation.

CHAPTER I

INTRODUCTION

Description of Community

Palm Beach County consists of a flat terrain, situated in the southeastern part of Florida. It is approximately 2,023 square miles in area. Palm Beach County is bordered by the Atlantic Ocean on the east, Broward County on the south, Hendry County and Lake Okeechobee on the west and Martin County on the north.

The census for 1980 indicates a population of 576,863 for Palm Beach County. The population grew by two-thirds in a ten year period of time. According to the University of Florida (1981), Palm Beach County lead all Florida counties in growth and received about 105 new residents each day.

Racially, the White population grew 70%. According to the 1980 Census, the White population comprises 85% of Palm Beach County. The proportion of Blacks in the county has declined from 17.5% to 13.41% in 1980. American Indians, Asians and other races account for less than 1/2% of the total Palm Beach County population (Area Planning Board, 1982).

The population in Palm Beach County is growing older. The 1980 Census for Palm Beach County states that three out

of 10 people in the county are 60 years old and only one in five is under 18.

The Chamber of Commerce of Palm Beach County states that the socioeconomic level of Palm Beach County residents runs the gamut of low socioeconomic levels to the highest socioeconomic levels.

Author's Work Setting and Role

The Association for Retarded Citizens (ARC) in Palm Beach County is a private, non-profit organization who services infants and preschoolers who are diagnosed as physically handicapped, mentally retarded, or high risk. In addition, ARC provides programs for mentally or physically handicapped adults over the age of eighteen. These programs available through ARC are necessary since they are the only agency in Palm Beach County which provides services for this population, according to the ARC program manual.

There are two services available for the infants and preschoolers. One is the Infant Intervention Program. This program was implemented for the purpose of home training for developmentally delayed infants (birth to two years) in Palm Beach County.

At present there are 37 infants enrolled in the program. An infant specialist, referred to as an Infant Trainer, visits the homes of the infants or sees them in a small group at an ARC preschool once per week. The purpose of the service is to teach parents how to stimulate the child's development in the areas of self-help, motor development, language training and behavior modification techniques. The parent then works with the child on the

goals established by the Infant Trainer on an on-going basis.

Another service ARC provides is the Preschool Program. Upon reaching the age of two, the children enter one of four preschool developmental centers in Palm Beach County. The child attends the preschool closest to his residence. It is not necessary to attend the Infant Intervention Program prior to the Preschool Program.

Currently the ARC preschools serve 57 children. Children who live in Boca Raton, Delray Beach, and Boynton Beach attend the First Presbyterian Church in Boynton Beach. Children residing in Lake Worth and West Palm Beach attend the St. Juliana's Church in West Palm Beach. Children from Lake Worth, Greenacres, and southern West Palm Beach attend the Free Methodist Church in Greenacres. Those children who live north of West Palm Beach attend school at the Immanuel Presbyterian Church in Lake Park. Each preschool is housed in a church. The churches allow the schools to utilize the space free of charge. ARC is responsible for cleaning, maintaining, and the electricity consumed by the school. The children are required to bring their lunch daily. Parents donate snacks and drinks. The Health and Rehabilitative Services (HRS) pays for each child's tuition in the Infant

Intervention Program and the Preschool Program regardless of income. The tuition also includes bus service.

The ARC program manual states that the goal of the preschool developmental program is to give the mentally retarded, physically handicapped, and/or high risk child "the opportunity to reach his or her maximum potential in life through early stimulation." Four areas of concentration are stressed in each child's Individual Education Plan (IEP): language skills, self-help skills, motor skills (fine and gross), and pre-academic skills.

Each of the four schools is staffed with four instructional aides, one supervising teacher, one bus driver and a volunteer program; in addition to two social workers, one program coordinator and one director of education for all four schools. Each school consists of 12 to 17 children.

The responsibilities of the instructional aides is to carry out planned lessons under the direction of the supervising teacher, participate in all aspects of lunch (including preparation, clean up and feeding), physical care of children (including diapering, toileting, grooming, and self-help skills). The turn over of instructional aides is high due to low salaries and the high level of responsibility.

The supervising teacher is required to plan parent meetings every three months, contact the social worker concerning client's needs, plan field trips and lunch schedules, send notices to parents, contact the public schools for placement, supervise instructional aides as well as administrative responsibilities.

The program coordinator is responsible for most of the administrative tasks related to the Infant Intervention Program and Preschool Program. She is specifically in charge of the fiscal management of all program budgets, compliance with ARC and HRS standards regarding health and safety and administration matters; hiring of all program staff members along with the educational director; assurance of all tasks necessary for the smooth transition into the infant intervention program, preschool program and public school system; assurance of full case load for every program; supervision of social workers; writing inserts into training manual regarding administrative tasks; maintaining records (staff and children's attendance, vacations, van maintenance); maintaining open communication with HRS staff regarding infant intervention referrals and waiting list; close contact with parents on infant intervention waiting list; training and evaluating transportation personnel;

assurance of proper maintenance of vans and teaching centers; scheduling parent conferences; development of preschool calendar and infant intervention schedule; recruiting and training-program for volunteers; and monthly report to executive director.

The director of education is the overseer of the Infant Intervention Program and Preschool Program. She is responsible for the following: program planning and implementing quality education for the Infant Intervention and Preschool Programs; complying with ARC's educational requirements; training and motivating each member of the Infant Intervention and Preschool staff except for transportation; supervising educational activities for both the infant and preschool programs (implementing quality lesson plans, monitoring IEP's, monitoring the educational achievements made by each child, consulting with supervising teachers and infant teachers regarding learning problems, evaluating staff); reporting monthly to the executive director; and maintaining open communication with program coordinator, social workers, speech-language pathologists and physical therapists.

The social worker is in charge of: processing referrals by follow-up home visits; determining eligibility; making

preschool placement, collecting medical, social, psychological, and educational reports; attending IEP staffings and parent conferences; assisting parents in arranging medical appointments and transportation, if necessary.

The author of this practicum is a speech-language pathologist who has been working with a physically and mentally handicapped population (cerebral palsy, Down's Syndrome, rare syndromes i.e., Mobius Syndrome, Treacher Collins, etc.) for nine years.

Initially, from 1975 to 1978, the author was employed at United Cerebral Palsy of Staten Island, New York. She was a member of an interdisciplinary team consisting of a teacher, physical therapist, occupational therapist, psychologist, nurse, biofeedback engineer, and was in close contact with the neurologist and orthopedist. This environment lead to the concept of working with the whole child and learning to apply related therapeutic techniques in conjunction with speech therapy. A true understanding and background information for working with the handicapped population especially the preschoolers and infants was obtained.

In 1978, the author completed The Neurodevelopmental

Training eight week course which strengthened already learned concepts pertaining to the handicapped early childhood population especially in the areas of relaxation, facilitation, respiration, and feeding therapy techniques. In the summer of 1981, the Neurodevelopmental Advanced Speech Workshop was taken by the author. The course stressed assessment and feeding techniques for the physically handicapped infant and young child, as well as communication techniques during mealtime.

In 1980, the author relocated to South Florida. She was surprised to find that the interdisciplinary approach did not exist in Broward or Palm Beach Counties for the physically handicapped population, mainly due to financial difficulties. The author was privately contracted to perform speech therapy services for the physically and mentally handicapped preschoolers and infants at the ARC preschool and infant intervention programs through funding provided by HRS. Due to financial deficits HRS discontinued this service twice in the past two years. The payments were reinstated in September-November, 1982, when the grant money was reissued.

In November, 1983, Bethesda-by-the-Sea, a church in Palm Beach County, awarded a one year grant to ARC for the

specific purpose of hiring a speech-language pathologist to provide speech therapy for the 90 infants and preschoolers ARC services. The amount donated was insufficient to hire a full-time speech-language pathologist therefore the author was hired as a part-time speech consultant. The responsibilities of this position consist of evaluating each child every six months to a year or as needed, writing speech goals and discussing them with the supervising teachers or infant trainers as well as teachers aides. Goals and therapy techniques are demonstrated upon request. The teaching staff at ARC are encouraged to observe or participate during the evaluation of a child. In September of 1984, the author was informed that ARC will be receiving $24,000 for speech and physical therapy under PL 89-313. The money will become available in November, 1984, and terminate in June, 1985.

The Palm Beach Board of Education, through Child Find, also provided speech therapy as well as physical therapy to the ARC preschools in Palm Beach County since 1980. The physical therapist and speech therapist visited each school once per month which was not sufficient for the needs of the children or teachers. As of June, 1983, this grant was terminated.

In January, 1984, physical therapy was provided to the children in the ARC programs through HRS until the grant expired in June, 1983. Since then ARC privately contracted the physical and occupational therapists to continue their services at ARC for a total of 17 1/2 hours each per month. ARC secured the money to provide this service from the proceeds of their newly owned thrift shop.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

ARC services a total of 90 infants and preschoolers. Ninety percent of these children were in need of speech therapy. In November of 1983 Bethesda-by-the-Sea, a church in Palm Beach County, awarded a grant to ARC for the specific purpose of hiring a speech-language pathologist to provide speech therapy to the 90 infants and preschoolers that ARC services. The amount donated was insufficient to hire a full time speech-language pathologist, therefore a part-time speech pathologist was hired (15 hours per week).

Eighty of the ninety enrolled in the ARC infant and preschool programs were in need of some form of speech therapy. The author was hired to service all 90 children during 15 hours per week. According to the American Speech and Hearing Association (ASHA) 1984 guidelines, the maximum caseload for a consultation program is 15-40 clients and 15-25 clients for direct service. A consultation program requires that the speech-language pathologist develop a clinical management program for the communicatively handicapped student and is responsible for training and instructing others to carry out the program. A direct

service program implies that the speech-language pathologist is responsible for the overall communicative habilitation/rehabilitation program for clients including diagnosis/evaluation, parent/teacher counseling, direct intervention, generalization, and continued monitoring of the student's progress (Committee on Language, Speech, and Hearing Services in the School, 1984). Therefore, whether or not the speech-language pathologist was going to assume a direct services or consultant's role, 80 clients far exceeds the suggested ASHA case load maximum. According to ASHA's guidelines, it would have been necessary to hire two to three full-time speech-language pathologists in order to satisfactorily service 80 children. Therefore, the children in the ARC infant intervention and preschool program received an insufficient amount of speech.

Before the grant was issued by Bethesda-by-the-Sea, speech therapy had not been offered to the children in the ARC infant intervention or preschool programs since June, 1983. Prior to this the Palm Beach County School Board, through Child Find, provided speech therapy five hours per month which was ineffective due to the insufficient contact time allotted. Many of the children's families were unable to afford private therapy and did not make an income low

enough to be serviced for free by Easter Seal (Crippled Children's Hospital for Children and Adults), or Children's Medical Services (CMS). CMS services for free all those children who are declared deaf or born with a cleft palate and whose families make below a set income (approximately $7,000). There was only one child in the program who was entitled to the CMS speech therapy program. A small percentage of the children (approximately 10-20%) enrolled in the ARC infant and preschool programs had private health insurance which covered 80-100% of speech therapy expenses.

According to PL 94-142, all exceptional children are entitled to free speech therapy between the ages of 2-21, although it is up to each individual state. Florida State Statute #232 states exceptional children from the ages of 3-21 may receive free speech therapy if the school board in the county within which the child resides provides such a service. The school board in Palm Beach County offers free speech therapy to children in grades kindergarten through twelfth grade. Therefore, exceptional children between the ages of birth to five were not entitled to free speech therapy.

Due to the lack of funds provided for speech therapy and the parent's knowledge of the importance of early

intervention (Irwin-Carruthers, 1981), 10 of the 90 children in the ARC program sought out private therapy. A few of these parents were lucky enough to have private health insurance which covered 80-100% of therapy fees. For those not covered under private health insurance, the parents secured a second job, borrowed money, or found other methods to raise money for their child's speech therapy expenses.

Once ARC hired the author to give speech therapy to the children in the infant and preschool programs, many of those parents who were not covered under health insurance dropped their children from private therapy (five children).

In general, a child who had a speech and/or language disorder would receive individual speech therapy from a speech-language pathologist one to five times per week for 1/2 hour sessions depending on the severity of the disorder. The parent and/or teacher was also shown by the speech-language pathologist how to carryout specific speech goals at home or in school.

Many individuals (parents, teachers, other professionals, etc.) were not aware of the fact that speech therapy could begin as soon as there was a suspected delay or an actual delay in speech, language, pre-speech, or feeding development. Traditionally, speech therapy was given

after speech had already developed or was absent by ages 5 or 6. Unfortunately, it is more difficult to work with a child at the age of 5 or 6 since the child may have already developed incorrect feeding and speech behaviors than if therapy occurred at an earlier age. With early intervention, the therapist could guide the development of speech and language and have prevented bad habits or inappropriate behaviors from developing (Morris, 1981). Facilitation of proper sucking; chewing; drinking from a cup; eating from a spoon; the coordination of respiration with swallowing and speech production; the coordination of the cheek, lips, tongue, and jaw for speech production were examples of feeding and pre-speech skills. Pre-speech skills such as the production of sounds and words also occur during the first year of life developmentally, as well as receptive language skills. Not only is it necessary to work with the child but the child's parents should be shown how to stimulate the child to communicate verbally. This may be accomplished through gestures, sign language, pictures, symbols and/or vocalizations.

Therefore, the author concluded that there was a lack of funds to provide a sufficient amount of speech therapy services to 90 infants and preschoolers at the ARC Infant Intervention and Preschool programs in Palm Beach County.

Problem Documentation

The infant trainers and teachers at the ARC programs determined that 80 children out of 90 enrolled were in need of speech therapy through the following assessment techniques: observations, doctors' and program referrals, and formal testing. The teachers administered the Alpern-Boll Diagnostic Test and the Early Learning Accomplishment Profile (Early-LAP) to each of the children enrolled in the program. These tests indicated that most of the children (80%) were functioning at least six months to a year below their chronological age in one or more of the following speech areas: expressive language, receptive language, feeding or communications skills. The author found similar results when the Sequenced Inventory of Communication Development (SICD) and the Pre-Speech Assessment Scale were administered. Doctors' referrals and reports from therapists, as well as records from others schools, recommended speech therapy for approximately 30% of the children in the ARC program. Parents of all 90 children indicated they wanted speech therapy for their child. A note was sent home in November, 1983, to all the children enrolled in the program. The parents were asked whether or not they wanted speech therapy for their child and whether

or not their child was receiving private therapy. All 90 notes were returned indicating the desire for speech therapy for each of the children in the ARC programs. Ten notes stated that their children were receiving private therapy and five were terminating this service now that ARC provided speech therapy for their children.

The author was hired to service all 90 children, although according to the American Speech and Hearing Association's (ASHA) 1984 guidelines, this far exceeded the maximum caseload for a consultant's program (ASHA suggested 15-40 clients).

Most of the parents were unable to secure free speech therapy for their children. The school board in Palm Beach County provided speech therapy for children between kindergarten (5 or 6 years) and 12th grade (17-21 years) unless the child had a 40% hearing loss, then (s)he was given a deaf education teacher twice per week at the child's preschool or at the child's home. CMS provides speech therapy for infants and preschoolers only if they are declared deaf or have a cleft palate. There was only one child in the program who was going to be serviced by CMS. Crippled Children's Hospital saw children on a sliding scale ranging from $17-32 a half-hour session. None of the

children in the program attended this facility due to the high cost and difficulty transporting the child back and forth.

Causative Analysis

When the problem of insufficient funds to properly service 90 infants and preschoolers with a speech and/or feeding disorder was analyzed, two areas were explored: the cause for the large number of infants and preschoolers with this disorder as well as the reason for the lack of sufficient funds to service these children.

Garner (1972) gives us an historical view of the handicapped. It was first thought by our ancestors that those born with a disability was the work of evil spirits and were therefore put to death. In the middle ages they were court jesters or beggars. In the 1600's the handicapped were put in hospitals or shelters. Finally, in the 1840's, the first workshop was formed. The handicapped entered the work force and began to declare some independence, as well as receive services to habilitate or rehabilitate the handicapped individual in order to function to his or her maximum potential. More and more handicapped individuals are now being referred for therapy. They are not thought of as hopeless.

There is a greater survival rate for newborns with

varying disorders due to the latest developments in technology. Similarly preventative medicine, tests, and surgery now occur prenatally (in utero), natally and post natally increasing the infant survival rate, thereby increasing the numbers of infants and preschoolers in need of speech therapy intervention. Similarly, according to Shprintzen, et al., (1982) there is a high frequency of speech, hearing and language disorders associated with birth defects.

Speech impairments are found in 4.2% of the population and the rate of speech impairments increases at both extremes of age (Fein, 1983). According to the Committee on the Prevention of Speech-Language and Hearing Problems (1984), speech and language disorders have the highest prevalence of any handicapping condition among preschool children. Among school age children, speech and language disorders are the second most prevalent handicapping condition (Committee on Prevention of Speech-Language and Hearing Problems, 1984).

Much of the money for rehabilitation and habilitation is allocated to the geriatric population in southeast Florida. The 1980 census for Palm Beach County indicates that three out of ten people in the county are 60 years old

and one in five is under 18. These statistics would persuade politicians to propose and pass legislations favorable to the majority of the population, in this case the geriatric segment. In many states Social Security Insurance (SSI) and/or Medicaid provides money for speech therapy for infants and preschoolers as well as adults. However, in southeast Florida, SSI and Medicaid provide funds only for the older population. From time to time HRS allocates monies for therapies and often prematurely terminates funds due to budget cuts and the termination of grants. This has occurred five times in the past three years at ARC. Just recently the physical therapist at ARC was hired in January, 1984, and terminated in June, 1984. Similarly, in September of 1982, the author was hired by HRS and funds were terminated in November, 1982.

There was a weak parent group in Palm Beach County. The parents organized three Cope groups---one in North Palm Beach County, one in Central Palm Beach County and one in South Palm Beach County. The groups consist of parents who have children with special needs ranging in age from birth to early adulthood. The attendance to their meetings was very small (fewer than ten at times), therefore making it difficult to form a strong enough support group to organize lobbies.

Fund raising attempts by the organization (ARC) or parent groups have not been as successful as they would have liked. The money raised from fund raising must be used to pay for other important needs, i.e. paper goods, equipment, an addition to the ARC main office in Riviera Beach, etc.

Many of the teaching staff have not received any formal training in the areas of speech and language development. They had a general idea of normal speech and language development and if a problem existed but they were unsure how to intervene.

Many of the profoundly retarded or severely handicapped children in the ARC programs required on-going therapy for at least six months to a year (McCracken, 1978) even before a noticeable difference was observed. Parents and teachers must be trained to identify small steps of progress. This would allow parents and teachers to reward and reinforce appropriate behaviors and accomplishments children made as well as motivate the teacher and parent to continue to stimulate a severely involved child (McDade & Simpson, 1984).

Some of the children, especially those in the Infant Intervention Program, have serious medical disorders which are life threatening. The parents' and teachers' first

concern should be survival, speech and language development should not be a priority. Although, it should be the teachers' and parents' obligation to focus in on the speech areas as well as others as soon as the child is declared medically safe for therapy.

Parents and/or teachers did not feel it was worth spending time working on speech goals with the severely involved or very low functioning child. They did not expect them to talk so they felt therapy was a waste of time. These individuals were not aware that there were other ways to communicate (sign language, gesture, electronic systems, eye gaze techniques, etc.) and speech therapy did not only consist of vocalizing words and sentences. Many parents were not aware of the significance of feeding therapy (Jonas, 1894) as a method of preparing the oral musculature for speech production as well as mealtime as a good opportunity to stimulate language skills.

Another problem which existed was the staff turnover, 10 out of 14 teacher's aides have left in the past six months. Since the teacher's aide salary is so low, many leave to secure higher paying positions or return to school. Therefore their knowledge goes with them and time had to be spent to train a new staff member. Similarly, children

- stayed in the program for a short time, then the family often relocated in search of a better program for their child or the family moved for better employment opportunities.

Parents' attendance to workshops or individual sessions with the speech-language pathologist was discouraging. This was due to a variety of reasons such as no transportation, parents both work, younger siblings at home, and lack of interest.

The Related Literature

In the past ten years, the emphasis in education has been on early intervention, as soon as a disorder was apparent or even suspected, intervention began (Connor, 1978). Intervention can occur as early as in utero (Fadiman, 1983) using ultrasound, amniocentesis, inserting a shunt or other surgical procedures to the unborn fetus. These innovations made miraculous changes in the newborn and toddler.

McKay (1983) has found that the short term effects have been found for early childhood intervention programs as brief as two months and as long as three years for programs directed primarily at the child (Palmer & Siegel, study cited in McKay, 1983), programs for the mother-child interaction (Levenstein, study cited in McKay, 1983), programs carried out in the home (Gordon, Guinagh & Jester, study cited in McKay, 1983), carried out in centers (Karnes; Miller & Dyer, studies cited in McKay, 1983), and those programs starting with infants (Gordon, et al.; Herber; Ramey & Haskins, studies cited in McKay, 1983). The cognitive responsiveness as a result of these programs has been well documented. However, McKay's findings indicated that the long-term effectiveness of early childhood

intervention programs presented a mixed picture of success and failures. On the other hand, Dr. Samuel Meisel at the 1984 NOVA University's Summer Institute spoke of successes of early intervention programs and that long-term effects still continued for those in an early intervention program in at least one or more areas of learning (i.e. social, cognitive, etc.). He also stated how early intervention programs have also lessened the need for other services (remedial in nature) for these children. Marge (1984) also cited as one of the long-term effects of early intervention as being fewer placements in special education programs and fewer retained in a grade. She also stressed infants who were high risk for language disorders eliminated or ameliorated the disorders using an early intervention program. As far as early intervention regarding language therapy, Leopard (study cited in Marge, 1984) found the gains to exceed the rate seen in normal development. Marge also stated that the implications for improved communication behavior was a result of early intervention and she, therefore, felt this was an important strategy in any program of prevention.

Along the same lines, Pines (1982) stated that infant stimulation was one of the least known but most successful

and cost-effective educational programs supported by the federal government in the last decade. She felt it was successful because it capitalized on the plasticity of children in their early years and cost effective since parents performed most of the teaching.

Although early intervention programs have been publicized and caught the public's eye since the 1960's as a result of Head Start, there were not any programs for infants and very few for preschoolers 20 years ago. Garner (1972) presented an historical view of the handicapped. He discussed how the disabled individual was disposed of by our ancestors in pre-recorded times. Those born with a handicap were thought of as the work of evil spirits, some were starved to death. During the post Roman era, the disabled were court jesters and during the days of the tribes the disabled weaved baskets or flaked flint for weapons. In the Middle Ages, they were beggars or put in asylums. In the 1600's, the disabled were still discriminated against and sent to hospitals and shelters. Finally, in the 1840's, the first workshop was opened. The handicapped were finally given a chance to live in society although still segregated. Now, handicapped individuals are a part of society. They live in apartments or houses with other members of our

society and are entitled to an equal education from the ages of 2-21 under PL 94-142.

Fein (1983) reported that 4.2% of our population have speech impairments. Among preschool children, speech and language disorders have the highest prevalence of any handicapping condition and among school age children speech and language disorders are the second most prevalent handicapping condition (Committee on the Prevention of Speech-Language and Hearing Problems, 1984). Furthermore, 71% of all handicapped preschoolers are diagnosed as having a speech or language impairment. Siegel-Sadewitz & Shprintzen (1982) reported that there is a high frequency of speech-language and hearing disorders associated with birth defects. Konigsmark & Gorlin (study cited in Siegel-Sadewitz & Shprintzen, 1982) described over 150 syndromes with a hearing loss or deafness and Cohen (study cited in Siegel-Sadewitz & Shprintzen, 1982) had described over 150 syndromes with clefting of the lip and/or palate. Bergsma (study cited in Siegel-Sadewitz & Shprintzen, 1982) reported 198 syndromes with mental retardation as a symptom. The article gave a list of over a 100 syndromes, the type of speech disorder associated with it, as well as, references for each syndrome and clear photographs of many identifying

features of several syndromes. It is a good reference list for those working with infants and preschoolers with syndromes.

Work with handicapped infants and preschoolers in the late 70's and early 80's brought up the issue of effective parent training within the natural environment (home) or instructional environment (school or clinic). Hall & Klein (1983) described learning in the natural environment as "functional training". They stated that functional training taught the child the appropriate use of the skill at the time it was acquired. Lovaas, et al., (study cited in Hall & Klein, 1983) found that the more extensive the parental involvement with their child's training the more gains shown in follow-up measurements one year after professional intervention was terminated. Furthermore, changes in behavior that were limited to instructional environments had little long range benefits for the children.

The home environment concept also allowed for the child to generalize concepts beyond the specific training provided by professionals as well as continue the specific training beyond the period of direct intervention (Oldle, Greer & Anderson, study cited in Hall & Klein, 1983; Spradlin & Seigel, 1982).

Researchers have found many other positive aspects of natural environment learning: parents were successful at teaching their child new skills (Arnold, Sturgus & Foreland; Baker et al.; Baker & Heifetz, studies cited in Hall & Klein, 1983); there were numerous occasions for language to occur and ample reinforcement when it did (Spradlin & Seigel, 1982); parents have the most frequent and consistent access to the child and are involved in the widest variety of communications as well as innumerable reinforcers (MacDonald, Blott, Gordon, Spiegel & Hartmann, study cited in Hall & Klein, 1983). Hall & Klein (1983) pointed out that when the parent provides most of the child's training and the professional provides only those services for which they had specialized training, this may in turn, free the professional to serve more children effectively. This method of providing services for children allows the child to receive the benefits of specialized professional services and comprehensive home training.

Spradlin & Seigel (1982) explained the reason that therapy which takes place in a clinical or laboratory setting did not generalize was because the clinician used the same set of objects, pictures, reinforcement schedules, etc., over and over. They gave good recommendations for

speech therapy which takes place in the natural environment and the clinical environment. These suggestions were discussed with the parents and teachers at the workshops at ARC presented by the writer of this practicum. Sandler, Coren & Thurman (1983) included instructions on data keeping in their training program for parents of handicapped children. They found that this procedure increased the parents use of positive feedback for the child's correct responses. The parents became more motivated when they were able to see (in a chart form) that the child made accomplishments.

The special education literature abounded with intervention programs advocating a variety of roles that play in the child's remediation process in the seventies, such as the Portage Project (Shearer & Shearer, study cited in McDade & Simpson, 1984); Read Project (Baker, Bringhtman, Heifetz & Murphy, study cited in McDade & Simpson, 1984); Birth to Three Curriculum (Bangs, study cited in McDade & Simpson, 1984); Parent Programs for Developmental Management (Denhoff & Hymann, study cited in McDade & Simpson, 1984); Environmental Language Intervention (MacDonald, Blott, Gordon, Spiegel & Hartmann, study cited in McDade & Simpson, 1984); Teach Your Child to Talk (Pushaw, study cited in

McDade & Simpson, 1984); Modification of the Mother-Child Interchange in Language, Speech and Hearing (Clezy, study cited in McDade & Simpson, 1984), etc.

Although parent involvement was considered an essential part of clinical services, very few clinics throughout the United States and Canada utilized such a treatment program. Cartwright and Ruscello (study cited in McDade & Simpson, 1984) conducted a survey of clinics and training programs in communicative disorders throughout the United States and Canada. Their results revealed 89% of their respondents indicated the importance of parent-child intervention programs but only 51% actually organized such programs. Of those who offered a parent training component, 62% reported that passing out pamphlets and other written material was the approach utilized. Less than 11% indicated that videotapes were utilized in such training programs. One reason for this low percentage of parent-child training approach was the clinician's reluctance to become actively involved with parents. Therapists felt insecure since parent training was not part of their clinical practicum experiences. McDade & Simpson (1984) presented a good program on how to teach a parent to be a language facilitator. They discussed approaches to working with

parents as well as how to implement a parent-training program using videotape equipment to evaluate parent's skills.

Butler (1974), Boone & Prescott (study cited in Butler, 1974), Russo & Owens (1982) and McDade & Simpson (1984) developed methods to objectively record and evaluate therapist or trainer and child. It was a continuous interaction reinforcement technique that was utilized along with a videotaping of a therapy session. Russo and Owens (1982) statistically analyzed their taxonomy of interactional behaviors used for parents of preverbal/early verbal children. Their taxonomy was utilized by four judges to rate 40 one minute videotaped segments of parent-child free play. The results were compared to four judges' subjective ratings of the segments. They came up with 10 objective behaviors which were highly correlated with the overall subjective ratings. Parts of this scale were utilized by the author (Appendix A).

Not only could parents effectively aid in teaching infants and preschoolers but paraprofessionals also are helpful language facilitators. Shinn-Strieker (1984), Frith & Teller (1982) discussed how paraprofessionals assist in the provision of special educational services.

Shinn-Strieker identified the effectiveness of training paraprofessionals in the areas of assessment of language, hearing disorders and direct speech-language pathology services under a speech-language pathologist's supervision. These paraprofessionals were referred to as communication assistants by the American Speech and Hearing Association (ASHA). ASHA has established guidelines regarding the communication assistant. These guidelines are utilized by public school administrators. In Shinn-Strieker's review of the literature, she cited a program developed by Jelinek which was similar to the author's work setting at ARC. Jelinek trained and employed paraprofessionals to work in five Head Start Programs with 99 preschool handicapped children. He trained the paraprofessionals to assess speech problems and administer therapy via special individualized learning packets developed by speech therapists. The results indicated significant gains in the performance of the children who received therapy with the trained paraprofessional.

Frith & Teller (1982) discussed the roles of a paraprofessional in programs for hearing impaired children. They presented the practical ways in which paraprofessionals could be utilized in special education settings as well as

responsibilities which should never be assigned to a paraprofessional i.e. primary responsibility for writing IEP's, initiating formal contact with parents without the approval of their supervisor, etc. They concluded that the paraprofessional could enhance the capability of a school system to provide a free and appropriate education for all children.

The late 70's and 80's also brought outstanding technological accomplishments into the classroom, clinic and home. Videotape recorders (VCR) and microcomputers are now seen often in schools and at home. Unlike the microcomputer which is still somewhat complicated to operate, the VCR is as easy as a tape recorder to work. The VCR's and cameras are also more affordable and lighter in weight. A whole unit (VCR and camera) can be purchased for $1200 (Sutton, 1984). The literature offered much research in the uses of the VCR. The literature consisted of the following uses for videotape equipment: evaluation and self-evaluation, instruction, diagnostics and counseling.

Those articles pertaining to self-evaluation consisted of therapists and teachers self-evaluating their teaching techniques (Butler, 1974; Hoerner, 1972; Lemmer & Drake, 1983; Boone, 1970; Estus et al., 1980) as well as mentally

retarded students seeing their performance in school and at home (Burnell, 1972). Students, therapists and children had a positive reaction to the tapings as soon as they overcame the initial stage fright fears. Supervisors found this an easy method to evaluate a student or instructor's teaching techniques. The supervisor need not be present during an evaluation and it was easy to go back on the tape to pinpoint specific negative and positive aspects of a teaching technique. It proved to be time and cost effective (Lemmer, 1983).

Leith, et al., (1974) and Thompson & Hixson (1984) described the diagnostic uses of videotapes. Children and teachers were videotaped before the therapy training program was initiated and once again they were retaped performing the same tasks after being placed in a therapy training program. In this way one had a record of performance prior to and after intervention. Most professionals felt that it was an effective method to carryout diagnostic and evaluative procedures (Flahive, 1976).

The videotape recorder was also used as an instructional aide; as a teaching tool in a clinical setting (Billeaud, 1976); for inservices (Carpenter, 1979); training speech students (Billeaud, 1976); and teaching children

concepts (Hofmeister, 1972; Striffler et al., 1977). All programs felt the VCR was invaluable and successful. Carpenter (1979) took it a step further by using his video recording to conduct inservice programs. In order to teach a large number of educators at one time, a multipoint closed circuit television network was connected to the entire state university system (13 campuses). This technology enabled viewers to respond to the featured speaker in a manner similar to a telephone conversation. A questionnaire to all participants revealed that 83% of the viewers agreed the talk-back portion of the program was useful.

The Muskegan Developmental Center, a residential facility in Michigan (Flahive, 1976) and speech and hearing therapists in a California school district (Bureau of Elementary and Secondary Education, 1972) discussed the many uses of videotape recordings. The VCR was successfully used for direct instruction for children, inservice training, counseling, identification, treatment, and evaluation of speech and hearing problems, self-evaluation and training volunteers. The school district in California used a van to provide a mobile classroom allowing several schools to participate in the uses of the VCR equipment. In this way 2,366 students received services from a staff of 12

therapists.

The author has concluded from this literature review that early intervention, parent and paraprofessional training programs and videotape recordings are on the whole successful intervention techniques which could be successfully used, as well as time and cost effective when working with a population of mentally retarded, developmentally delayed and/or physically handicapped infants and preschoolers.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Statement of General Goals

The goals for this practicum were for parents and teachers working with physically handicapped, mentally retarded and developmentally delayed infants and preschoolers to carryover speech goals established by the speech and language pathologist. In this way the children would receive more intense therapy. The parents and teachers could learn the normal developmental stages of receptive language in order to determine which goal follows, how to simplify a goal, how to reinforce appropriate behaviors, and how to incorporate the speech goals into the natural environment (at home) and/or into the instructional environment (at school)(See Chart I on page 41).

CHART I

Goals / Criteria / Results

Goals / Objectives	Evaluation Instruments / Administration Schedule	Criteria for Success	Results
1. Carry out speech goals in natural and instructional environments.	a. Questionnaire (App C)/ prior and after implementation	a. 10% increase in "yes" responses to questions #6 & #7	a. question #6=55% increase in "yes" responses #7=51% increase in "yes" responses
	b. Observations/Interactional Analysis Chart (App A)/prior & after implementation	b. Parent/Teacher 10% increase in 1E responses 10% increase in overall responses (1-10) 10% decrease in #10 responses Child 10% increase in #1 responses 10% decrease in #3 & #4 responses	b. Parent/Teacher 100% utilized 1E responses 17% increase in 1E responses 17.5% overall increase in all responses (1-10) 100% produced fewer #10 responses Child 100% produced #1 responses 45.5% increase in #1 responses 100% produced fewer #3 & #4 responses 29% decrease in #3 responses 30% decrease in #4 responses
2. Determine which goal to proceed to.	a. Questionnaire (App C)/ prior and after implementation	a. 10% increase in "yes" responses to question #2.	a. question #2=44% increase in "yes" responses
	b. Recording Form (App E)/ during implementation	b. 50% of parents and teachers progress to next developmental goal	b. 100% of parents and teachers progressed to next developmental goal.

Videotape Library
page 41

Goals / Objectives	Evaluation Instruments / Administration Schedule	Criteria for Success	Results
3. Children will receive more therapy	a. Recording Form (App E)/ during implementation	a. At least one date per month recorded	a. All (30) parents and teachers (100%) recorded at least 5 sessions (one per month).
	b. Videotape Library Circulation Form (App B)/during implementation	b. Utilized 3 times or more per child.	b. 100% of the parents & teachers made use of the videotape library Tapes were borrowed at least 5 times per child
4. Learn to simplify goals	a. Questionnaire (App C)/ prior to and after implementation	a. 10% increase in "yes" responses to question #4	a. question #4=62% increase in "yes" responses
	b. Recording Form (App E)/ during implementation	b. 10% of all teachers & parents simplify goals on recording form	b. 50% of all teachers & parents simplified goals on the recording form
5. Teachers parents & children will become more motivated to carry out goals & learn	a. Questionnaire (App C)/ prior to and after implementation	a. 10% increase in "yes" responses to questions #7 & #9, 50% select multiple choice #4 to question #8	a. question #7=51% increase in "yes" responses #8=100% selected #4 #9=41% increase in "yes" responses
	b. Video Circulation Form (App B)/ during implementation	b. 10 or more parents or teachers make use of the videotape library	b. 100% of the participants made use of the videotape library, 15 parents, 15 teachers in addition to 3 grandparents, 2 aunts & 3 baby sitters (total of 38 individuals).

Goals / Objectives	Evaluation Instruments / Administration Schedule	Criteria for Success	Results
6. Learn how to reinforce appropriate behaviors utilizing the correct reinforcer	a. Observations/Interactional Analysis Form (App A)/prior to & after implementation	a. Decrease in 1B,1C & 1D responses 10% increase in 1E (natural reinforcer)	a. 100% of parents & teachers learned to use natural reinforcers, Decrease in 1B, 1C & 1D for both parents and teachers, 17% increase in 1E responses for both parents & teachers.
	b. Questionnaire C (App C)/prior to & after implementation	b. 10% increase in multiple choice 5 of question #10	b. 48% increase in multiple choice 5 of question #10
7. Children will progress in the area of receptive language	a. SICD b. Alpern-Boll c. Early-LAP (Administer a, b, & c prior to and after implementation)	a, b, & c. 50% of the children utilizing the videotapes will progress to the next level of development according to the scale utilized	a, b, & c. 100% of the children progressed in the area of receptive language on the Alpern-Boll and Early-LAP, 93% of the children (14 out of 15) progressed at least 4 months on the diagnostic tools utilized.
	d. Recording Form (App E)/ during implementation	d. 50% of the children will accomplish one or more goals	d. 100% of the children accomplished two or more goals

Note:

All goals relate to parent/teacher behaviors unless otherwise specified.

Videotape Library
page 43

Behavioral Expectations

After the implementation of the practicum parents would be able to effectively carryover the speech and language pathologist's goals for their child in the natural environment at home. Similarly, the teachers would be able to effectively carryout the speech goals in the instructional setting at school. Both the parents and teachers would learn how to incorporate these goals into the natural and instructional setting so that goals and techniques would not be memorized but conceptualized in order to be worked into the course of the day. The parents and trainers would also learn how to motivate the child to learn, breakdown the goals so that they could be easily accomplished, learn normal receptive language development, learn how to reinforce appropriate behaviors, learn to determine the level to start working with a child, what materials to use and determine when the goal was accomplished.

The parents were expected to actively participate in this practicum. The children would score higher on the readministration of parts of developmental scales (Alpern-Boll, Early-LAP and SICD). Parents and teachers would learn how to chart accomplished goals and would be,

therefore, more motivated to work with the child when they saw the child's progress (Sandler, Coren & Thurman, 1983). Similarly, the parents and teachers would feel better about their teaching abilities.

The following assessment instruments were utilized: the Alpern-Boll and the Early Learning Accomplishment Profile (Early-LAP). These two assessment tools are utilized by the teachers at ARC every six months for each child. The author administered the Sequenced Inventory of Communication Development (SICD) to each child before and after intervention. A random sample of teachers and parents were videotaped before and after implementation of the solution strategy. An objective observational tool for parent-child interaction was utilized in order to compare the videotapes. In addition, a questionnaire to teachers and parents and other participants before and after implementation demonstrated whether or not the solution was successful. Lastly, the number of parents who made use of the videotape library (Appendix B) was an indication of whether or not more parents were motivated to carryover speech goals with their child than prior to implementation.

The following unexpected outcomes occurred as a result

of the implementation of this practicum. Parents were interested in seeing the same intervention techniques utilized in related developmental areas, i.e. physical therapy, occupation therapy, cognitive abilities, etc. This type of information was noted on the comment section of the questionnaire (Appendix C) as well as during conversations and workshops. Others in the community having normal children as well as parents of special children, showed an interest in the program by calling ARC or asking other parents for information. The school system's therapists, teachers, and parents also expressed an interest in the use of the speech program. This was noted on the circulation form (Appendix B) and by word of mouth from the ARC parents. As a result of this program, parents became more interested in participating in other ARC programs and cooperative with the teachers once they saw the benefits their children gained from their participation. There was better attendance to the parent coffees at each school once per month as well as better attendance at the North, Central and South Cope groups once per month. Due to the success of the proposal, the author will present a grant proposal to several foundations as well as the state and federal government to

secure money to continue the practicum for another two years.

Evaluation Instruments

The Alpern-Boll and Early-LAP assessment scales were chosen since all the teachers were familiar with these tests and each child in the ARC program has taken this test at least once. The teachers were required to administer these diagnostic tests once every six months. Therefore it was possible to obtain a score before the program was initiated and after its implementation. In four cases it was possible to compare a child's progress for six months without the speech videotape library program and five months with this speech program. Similarly, the SICD was chosen since all the children in the ARC program have taken this test at least once. It is re-administered every six months to a year depending on a child's progress. The teachers and parents were familiar with this assessment tool. The SICD is administered only by the speech-language pathologist. All the children received the SICD before and after the implementation of the speech program. Once again, in some cases, it may be possible to note the rate of progress six months before the implementation of the speech program and after five months of the speech videotape library program.

Of the 90 infants and preschoolers in the ARC program

23 children, at the beginning of the study, were functioning below a 12 month level receptively. During implementation, three relocated, two died due to upper respiratory conditions, one dropped out of the program and two became very ill (frequently in the hospital). Therefore, 15 children (12 in the infant program and three in the preschool program) participated in the Speech Videotape Library Program.

The questionnaire (Appendix C) was sent to all parents and teachers who participated in the speech program. It was filled out in September, 1984, before the implementation of the speech program and once again at the end of the speech program. The participants filled in the last four numbers of their Social Security number and school the child attended in order to compare responses by the same person before and after the implementation of the speech program.

One parent and one teacher from one of the preschools and four teachers and four parents from the infant intervention program were randomly selected to be videotaped before and after the implementation of the Speech Videotape Library Program. The only criteria for selection was that the child, parent and teacher would be participating in the

program and they planned to continue working with the child for at least six months to a year and planned to remain in the ARC program for six months to a year. An Interactional Analysis Chart (Appendix A) was used to record parents' and teachers' responses during a therapy session with a child. This approach was an adapted version of the Russo Owens (1982), McDade & Simpson (1984) and Boone & Prescott (study cited in Butler, 1974) parent-child interaction charts. See Appendix D for a definition of the terms on the Interactional Analysis Chart.

This chart enabled the author to record the types of responses exhibited by a teacher or parent after the child responded. For example, if the child pointed to the object requested, the child produced an appropriate response. The parent or teacher may have given the child a Cheerio, praised the child (good boy), gave directions to have the child reproduce the answer, etc. By coding the child's and parent's/teacher's behaviors as they occurred, one would be able to obtain a record of the interactions that were observed during the sampling period. The charting of the parent's/teacher's behaviors in response to the child's behavior occured during the first ten minutes of therapy.

The number of adult and child responses varied from child to child and adult to adult during this time period.

The Videotape Circulation Form (Appendix B) indicated the number of parents and teachers as well as other staff members who made use of the videotape library, how often, in addition to whether or not it was useful for the child with which they worked. Similarly, the Recording Form (Appendix E) would indicate if the parents, teachers, and children were successful in teaching and learning the goals being taught. It would determine if the teacher knew to which goal to proceed. In addition, the Recording Form would show how often the child was worked with, and if the teacher could simplify the goals.

Once the author received the results from the three assessment instruments (SICD, Early-LAP, Alpern-Boll) given before and after implementation, the scores would be compared to see how many months the children have progressed during the implementation phase (workshops and viewing of videotapes) of the speech program (six month period). With some children it may also be possible to compare their progress to last year's scores which reflected gains without the use of a videotape library. The information is clearly

CHART II

Test Results

Child	1	2	3	4	5	6	7	8	9	10	11	12	12+
1				ESA								ESA	
2	S_1A_1			ESA								ESA	
3		ES	A					S	EA				
4		ESA		ESA									
5				ESA				SA	E				
6				ESA				S	EA				
7				ESA				SA	E				
8				S_1A_1				SA	E			SA	E
9								S	EA			S	EA
10								SA	E			SA	E
11		S_1A_1		S	EA								ESA
12		S_1A_1		S	AE							SA	E
13		S	EA					S	EA				
14		S	EA					S	EA				
15		S	EA					S	EA				

Note:

S=Sequenced Inventory of Communication Development (SICD)

A=Alpern-Boll Developmental Profile

E=Early Learning Accomplishment Profile for Developmentally Young Children Birth to Thirty-six months (Early-LAP)

S_1A_1=SICD and Alpern-Boll test results administered 6 months prior to implementation.

S,A, or E=The first time these letters appear for each child indicates test results prior to implementation. The second time S, A, or E appears refers to the test results after implementation.

ESA or SA=Indicates those children who tested out age appropriate on the receptive portions of the assessment tool utilized.

visible in a chart form (See Chart II, page 52) having pre and post test scores side by side. The criteria for success was that at least 50% of the children progressed to the next level whether it be a month on the Early-LAP or four months on the SICD.

The questionnaires (Appendix C) were used as a tool to determine the speech program's success by comparing the percentages of (1) yes's on the pre and post implementation questionnaires and increase in #5 responses to question 10 (something directly related to response). There should be at least 10% more "yes" responses or #5 responses to question #10 on the questionnaire filled out after the viewing of the videotape library (see Chart I on page 41).

The following questions on the questionnaire (Appendix C) relate to the goals of the Speech Videotape Library (see Chart I, page 41). Questions #6 (Are you confident the techniques you used to teach speech goals are the appropriate ones?) and #7 (Are you successful in teaching a speech goal?) were used to determine if the videotape library was successful in training teachers and parents how to carryout speech goals in the instructional and natural environments respectively (goal #1). Similarly, the response

to question #2 (Do you know which goal to work on next?) was utilized to determine if parents and teachers knew the next goal to proceed to (goal #2). Question #4 (Do you know how to breakdown long term goals into smaller steps?) was one tool used to find out if teachers and parents could simplify goals (goal #3). Questions #7 (Are you successful in teaching a speech goal), #8 (Who should teach speech goals?) and #9 (Do you feel you are successful in motivating a child to learn?) helped to determine if teachers, parents and children became more motivated to carryout goals and learn (goal #5). Lastly, parents' and teachers' success at learning how to reinforce appropriate goals (goal #6) was partly based on question #10 (What type of reinforcers do you use to reward the child for his or her appropriate responses?). The parents and teachers indicated success in this area by (at least 10%) circling answer #5 (something directly related to response).

The Interactional Analysis Charts (Appendix A) would demonstrate the program's success by noting a greater number of correct and appropriate responses and fewer inappropriate and incorrect responses on the child's section of the form. The percentage of incorrect and inappropriate responses

would be compared to the correct and appropriate percentages on the post implementation form. Similarly, there would be at least a 10% increase in the total number of behaviors made by the parents and teachers and a decrease in physical, edible and tangible reinforcers (since there should be more appropriate reinforcers utilized) and fewer unrelated responses. The percentage of responses of all teachers' and parents' behaviors pre and post implementation would be compared. The criteria for success was at least a 10% increase in teacher and parent behaviors except for unrelated responses and physical, edible, and tangible reinforcements. There should be a 10% decrease in unrelated responses. The child's, parent's and teacher's behaviors on the Interactional Analysis Chart was charted to make the comparisons easier to see (See Chart III, page 56). The results of the pre and post Interactional Analysis Charts (Chart III) would be used to help measure the success of the following goals. Teachers and parents can carryout speech goals in the natural and instructional environments and the parents and teachers will learn how to reinforce appropriate behaviors (see Chart I on page 41).

The Videotape Circulation Form (Appendix B) would

CHART III

Interactional Analysis Results

Response	Response 1 A	B	C	D	E	2	3	4	5	6	7	8	9	10	Total	Child's Responses 1	2	3	4	Total
Teacher pre	22	3	4	1	2	14	9	3	3	3	14	8	7	12	105	2	8	10	7	27
%	20	3	4	1	2	13	9	3	3	3	13	8	7	11	100	7	30	37	26	100
Teacher post	5	2	1	0	20	15	11	15	6	5	19	18	6	1	124	15	9	1	1	26
%	4	2	1	0	16	12	9	12	5	4	15	14	5	1	100	58	34	4	4	100
%Differ					14									10	19	51		33	22	
Parent pre	10	16	8	2	2	4	4	2	2	5	5	5	10	12	87	2	4	8	10	24
%	11	18	9	3	2	5	5	2	2	6	6	6	11	14	100	8	17	33	42	100
Parent post	4	6	0	0	22	12	12	12	3	2	10	8	7	2	100	12	10	2	1	25
%	4	6	0	0	22	12	12	12	3	2	10	8	7	2	100	48	40	8	4	100
%Differ					20									12	16	40		25	38	
Parent/ Teacher %Differ					17									11	17.5	405		29	30	

Note:

Teacher or Parent pre and post responses=The total number of teachers or parents responses obtained from completed Interactional Analysis forms (Appendix A).

%=The percentage of a response was calculated by determining the percent of each individual response compared to the total number of responses. For example teacher pre implementation response number 6 was 3. Three is what percent of the total teacher pre implementation responses (total=105)? (3=?% of 105, answer 3%)

% Differ=(% difference) The pre implementation % minus the post implementation %. This is equal to the percent increase or decrease of a response. For example, Teacher response number 10, pre % 11 - post % 1 = 10% decrease in teachers inappropriate reponses after implementation.

indicate the number of individuals who utilized the videotape library. If more than ten parents made use of the library, this would indicate greater parent participation than programs in the past at ARC (less than five) as well as the child receiving more therapy. If the teachers and parents used it more than three times for one child, this would indicate that the teachers used it often enough to teach one or more goals to an individual child. If 10% more of the users of the videotape library found that the tapes were helpful to carryout receptive speech goals, then the program was useful to the participants. (see Chart I, page 41)

Lastly, if the users of the videotape library were successful in teaching a child one or more goals according to the Recording Form (Appendix E), then the children would have progressed in the area of receptive language skills. Similarly, if Appendix E shows children received more therapy than prior to the videotape library program, and if the forms also indicated the teachers and parents became skilled at breaking down goals and learned which goal followed developmentally, then the program would be a success (see Chart I for more details).

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

When planning for a speech program appropriate for the ARC infant and preschool programs, three areas were analyzed: 1) the expectations of such a program, 2) options or alternatives and issues and 3) the resources available.

The organization (ARC) wished to have speech therapy for each child in the infant and preschool programs who was in need of it. ARC also expected a speech evaluation and a written report listing each child's speech goals. They wanted the speech therapist to teach the teachers how to incorporate these goals into the teachers' lesson plans. ARC also expected the children to receive individual therapy or therapy in small groups (two to three) as well as larger (four to eight children) group language lessons.

The parents were interested in their child receiving individual therapy one to five times per week depending on the severity of the speech problem. They also wanted therapy to begin as soon as a speech or speech related (feeding) problem was detected.

The parents' goal was for their child to receive enough speech therapy to maximize their child's fullest

potential in the areas of feeding, communication, and speech and language development and minimize the delays and possible dysfunction from occuring, i.e., tongue thrust, mouth breathing, articulation disorders, etc.

The therapist would have liked to see all those children in need of speech therapy individually or in small groups (two to three) one to five days per week depending on the severity of the disorder. In order to enhance progress, the therapist wished to have contact with the teachers and/or parents on a regular basis to discuss techniques for carry over.

Due to the lack of sufficient funds the parent's, organization's and therapist's expectations could not be met. Therefore, a plan was made which was agreeable to all three groups of people.

Different options were investigated taking into consideration expectations and resources available. Five alternatives were analyzed: 1) seeing only those children who would benefit and progress the most out of a therapy program; 2) the therapist would see a small group of children (25) for individual or small group (two to three) therapy three times per week for 1/2 to one hour sessions and after two to three months rotate to another group; 3)

secure speech students from local colleges or universities to work with some children under the speech-language pathologist's supervision; 4) the speech-language pathologist would train teachers and parents to carryover speech goals through a series of workshops, manuals, demonstrations and handouts; and 5) the speech-language pathologist would train parents, teachers, paraprofessionals, and all other individuals who worked with the physically handicapped, mentally retarded, and/or developmentally delayed infant and preschooler through the use of a videotape library. The participants would be taught how to incorporate speech goals into the natural environment (home) and the structured environment (school).

The first option, seeing only those children who would benefit the most from a therapy program, would be a difficult decision to make. It would be especially difficult to determine which infants would benefit most. Many of the infants in the program were diagnosed as being blind and/or deaf and a year later, appear to see and/or hear. In addition, it would be hard to explain to a parent that their child was not going to receive speech therapy because they were too low functioning or too advanced. All the children would benefit from some form of speech therapy.

The idea of seeing some of the children for speech therapy three times per week and then rotating after a few months, would not meet with many parent's approval. This type of procedure would not be appropriate for those children who began to make great gains and then their therapy would be discontinued for nine months to a year while the other children were seen. This plan may work for children who go through spurts in speech development and were seen during these spurts. It is also very possible that children may not have been seen at all using this plan because of illness for a few months. They may have started therapy but due to illness missed the rest of their therapy and would not be seen again for nine months to a year. Some children may relocate and therefore never seen or seen for too short a time to benefit from speech therapy. Parents may also argue as to who received therapy first (the first group).

Getting speech students from local colleges or universities was a good idea but at present, there is only one school, Nova University, that offered a program in speech pathology in southeast Florida. Nova University's speech pathology program on the master's level had just started and they were not ready to send their students to

other facilities. However, students spending their externship at the ARC infant and preschool program would benefit both the speech students and children at ARC, although parents may not be pleased with this solution. Many parents feel that speech therapy students would not be well trained, or experienced to work with exceptional children. This inadequacy could be overcome by having the speech-language pathologist train the future therapists via workshops and individual demonstrations. Another issue which could arise was that of liability. These speech therapy students are not licensed and therefore the supervising speech-language pathologist is liable for their work. This becomes a great concern during feeding therapy since there is always the danger of a child choking on solid foods being introduced into their diet.

The fourth option, workshops and handouts, has been discussed in the literature for the past two decades. The National Joint Committee on Learning Disabilities in September of 1981 stated the ineffective aspects of inservices and workshops. They listed the following flaws: lack of appropriate planning and organization of goals and content; inappropriate selection and use of personnel; presentation of material irrelevant to needs of

participants; and lack of program availability.

In addition, workshops offered at ARC in the past have had poor parental participation. Approximately one to four parents per school attended a workshop or inservice out of 12-17 enrolled in each school. The parents absence during these sessions were due to lack of interest, other siblings at home, child ill, no transportation, forgot to mark the date on their calendar, etc. Teachers carried over the skills and techniques learned for a short time (one to two months) then went back to their old techniques or applied other ones. The parents and teachers rarely made use of the handouts distributed during the workshops. They often did not read the materials, misplaced them, filed them away forever or threw them out. Similarly, due to the large staff turnover and parents relocating, the information obtained at these workshops left with the individuals and often did not reach the new staff member or parent.

In addition, the teachers and parents became bored at the meetings especially when they exceeded 1/2 hour to 45 minutes. The participants had to be actively involved in order to hold their attention. Not enough information was usually conveyed in such a short time and therefore several workshops on each topic (two to four) were offered. This

presented a new problem, the participants forget the information presented at the first few workshops and review of the previous workshops took too long.

The literature suggested programs which gave information pertaining to the improvement of speech and language services through effective time and management techniques (Travers, 1983; Lemmer, 1983; Leith, et al., 1974; Butler, 1974). These programs were directed at the speech clinician or paraprofessionals (Creekmore & Creekmore, 1983), teachers (Hoerner, 1972), speech students (Billeaud, 1976; Butler, 1974), in addition to home centered programs in the 70's and 80's (Hall & Klein, 1983; Sandler, 1983; Spradlin & Siegel, 1982; McDade & Simpson, 1984). All these programs consisted of training <u>one</u> group of individuals (teachers, or parents, or students, etc.) to work with children with speech disorders utilizing workshops, inservices, manuals, and the like. These techniques have not been successful at ARC for many of the reasons previously mentioned.

Description of Selected Solutions

The fifth option, training all those individuals working with exceptional infants and preschoolers via a videotape library appeared to be the most appropriate technique for the ARC infant intervention program and preschool program. It consisted of a combination of the most successful ingredients of methods cited in the literature but adapted to satisfy the needs at ARC. The speech program had to address all staff and parents simultaneously. All those who spent time with the child receiving speech therapy should be aware of the child's speech goals in order to incorporate them into the course of the day. This may include the bus driver, grandparents, babysitter, etc. (Flahive, 1976). A videotape library would be viewed by this diverse group.

Many researchers discussed the need for a training program for parents to carryover at home during the course of the day for the following reasons: when therapy took place in a clinical or laboratory situation, generalization was more difficult (Spradlin & Seigel, 1982); parent involvement would free the speech-language pathologist to serve more children effectively (Hall & Klein, 1983); it would provide the child with more comprehensive training in

addition to receiving the benefits of specialized professional services (Hall & Klein, 1983); therapy could be conducted during those situations that normally arise during the course of the day instead of artificially contrived in a clinical setting (Schumaker & Sherman, study cited in Klein & Hall, 1983). Similarly, Lovaas (study cited in Hall & Klein, 1983) found the more extensive parental involvement with one's children, the more gains shown in follow-up measures one year after intervention was terminated. In addition, Spradlin & Seigel (1982) discussed the time and cost effectiveness of parents working with their child.

The videotape library concept was utilized by Billeaud (1976) to train speech and language students. The results of her study demonstrated that students achieved greater insight into the problem or technique at hand than they would have obtained from class lecture. Filmed presentations of a case promoted better analysis critique or understanding than the on-the-spot observation. In the same study, the graduates rated the use of the videotapes as superior or excellent and enjoyed the fact that many could view the tape at one time which could be disruptive when observing a therapist working with a child.

The author planned to train all those who work with

the handicapped, mentally retarded and delayed infant and preschooler. It was decided that it would be taught via workshops and a videotape library in order to learn how to incorporate speech goals into the course of the day. This involved combining three dimensions of a training program: counseling, education and training.

The major premise behind the proposed speech-training program was that the parent, teacher, bus driver, volunteer, etc., and not the child was the client; although this did not suggest that the child's immediate communication needs or attempts were ignored. The participants would assume the role of a language facilitator, one who responded appropriately to whatever the child said or did. The participants were scheduled to attend two workshops in order to teach different reinforcement techniques, attending behaviors, receptive language development (birth to one year), how to use the videotape equipment and videotape library, how to incorporate the goals into the course of a day, determine when a child accomplished a goal and which goal came next. The workshops also introduced Spradlin's & Seigel's (1982) recommendations for therapy in a natural and instructional environment (Appendix F and G).

Two workshops were to be presented in each school

since there was too much information to present at one workshop. Each workshop would last no more than 45 minutes. They would be offered at 10:00 in the morning so that the participants would be wide awake and alert and they would end well before hunger set in at 11:30. There would be a snack midway through the workshop provided by ARC. The workshops would be presented four times each so that if a participant missed one they could make arrangements to attend the workshop at another school. The parents and teachers of the infants would attend the workshop closest to their home or place of employment. Bus service and daycare would be provided for those who could not make other arrangements. Workshop II would be given one week after Workshop I since the author attended each school once per week. If it was impossible for an individual to attend one or both workshops, they would be videotaped in order to be viewed at another time or to train a newly hired staff member or newly enrolled parent.

It was the author's intent to avoid reproducing in the home the same artificial environment that was created in therapy and sometimes in the school setting. At home, the objects, events and circumstances to which children reacted to are real, not contrived. Imposing structure upon parent's

interactions with a child would impair the serendipitous manner in which it would normally occur (McDade & Simpson, 1984). McDade & Simpson (1984) stated that underestimating the prerequisite knowledge required to fully comprehend some of the linguistic concepts and behaviors therapists consider rudimentary was a common error therapists made when training parents to work with their child. For this reason the author was including normal receptive language development at the first workshop in addition to a handout (Appendix F). Similarly, the literature stated that parents must be able to predict the next stage of development to know the structure that expansion (immediate repetition of child's utterance to make it more grammatically complete) and models should take. This would be discussed during Workshop II (Appendix H).

A letter (Appendix I: Invitation to Workshops) was sent out one week before each workshop. This gave parents and other participants enough time to make necessary arrangements and yet not too much time to forget. The day before and that morning of each workshop the bus driver reminded all the parents about the workshop day and time.

The videotape library would present a view of working with a child in a structured setting on a specific behavior.

The viewer would then determine, with the speech-language pathologist's help, how to incorporate or use an alternate approach which fit into the setting and situation the child was in. For example, if the child was in the bus and the goal was auditory localization of sounds, the driver would point out the truck who was honking his horn on the left side of the bus. After a short time (two to three months), the participant would be able to incorporate the goal independently without the therapist's help.

After the editing of the videotape library, parents would receive a letter (Appendix N) informing them that the videotapes could be viewed once they had attended or viewed Workshops I and II. When the child had accomplished a goal, the viewer was ready to watch the next goal on the videotape, the trained participant would indicate the goal and date accomplished on a Recording Form (Appendix E). The participant then progressed to the next goal on the videotape if it was appropriate for that child. Sandler (1983) discussed how a parent became more motivated working with their child when they saw progress on a form.

The Speech Videotape Library Program appeared to be the best choice since it was the most economical and time effective. Additional staff was not needed. The videocamera

was set on a tripod so that the author could film her own sessions without assistance. The possibility of having the therapy sessions videotaped at the Spanish River High School studio was being explored with the executive director at ARC and the principal of the high school (Appendix J), as well as securing money under PL 89-313 for the funds to purchase videotapes and additional editing.

As a result of this speech program children would receive therapy five to seven days per week, evaluation procedures would be made consistent. The same assessment instruments the teachers and parents were familiar with were to be utilized (Alpern-Boll, Early-LAP, and SICD). Parents as well as others did not have to attend the workshops if this presented a hardship since it could be viewed on the videotape. The videotapes could be borrowed for home use or viewed at a friend's or neighbor's house, public library or at the ARC or public school.

The speech-language pathologist would have more time to work on speech areas that the participants do not have the expertise for, i.e. communication boards, articulation therapy, etc. All those working with the infants and preschoolers in the ARC preschool would be addressed simultaneously. There would be better generalization of

concepts in addition to longer lasting results according to the literature (mentioned on previous pages). The videotapes are more interesting for participants than lecture and less disruptive to the children. The tapes can be viewed over and over and can easily train new parents and staff. In addition, ARC's, the parent's, teacher's, and author's expectations were best accomplished utilizing the videotape library technique (mentioned on page 44). ARC did not have to purchase equipment since IBM donated $3,000 (July 1984) to purchase videotape equipment for three of the four schools. The fourth school received funds to purchase their videotape equipment from the church they were housed in as of December, 1984 (First Presbyterian Church, Boca Raton). Other resources available were the dedicated and cooperative staff, teachers and children at ARC. In addition, the ARC schools were supplied with the latest equipment and materials to work with the physically and mentally handicapped infant and young child.

The speech goals on the videotape library (Appendix K) consists of 49 receptive language skills from birth to one year lasting no more than ten minutes each. The goals (Appendix K) and the normal receptive language development list (Appendix F) were developed from: the three assessment

tools utilized (Alpern-Boll, Early-LAP, & SICD); The Communication Game (Reilly & Stark, 1980); 0 to 3 Years An Early Language Curriculum (Reidlich & Herzfeld, 1983); Brigance Diagnostic Inventory of Early Development (Brigance, 1978); Vulpé Assessment Battery (Vulpé, 1979); and Responding to Infants The Infant Activity Manual 0-30 months (Moyer, 1983). The therapist was responsible for providing the participants with a speech evaluation for each child which states the goal or goals to be viewed on the videotape library. The goals are located on Appendix K: List of Goals on Videotape. This gave them the tape number in order to easily locate one of the 49 ten minute sessions. Footages could not be used because they differed from video cassette recorder (VCR) to VCR. The tapes would be viewed to give the participant therapy suggestions to be incorporated into the child's environment (home, school, bus, etc.). The viewer would then carry out the speech goals with the child and record daily the child's progress (Appendix E).

Receptive language skills were chosen as a beginning of a three year long project consisting of Receptive Language Skills, Expressive Language Skills, Communication Skills, and Feeding Therapy Skills. The first segment, Receptive Language Skills will be a model speech program. If

it proves to be successful (see Chapter III, Anticipated Outcomes and Evaluation Instruments), the author plans to compose a grant proposal to secure the money necessary to complete the next two years.

Speech and language was divided into receptive and expressive language skills since the teachers and parents were familiar with this breakdown. In addition, receptive language skills develop first according to some researchers. The literature states that congnition preceeds expression, although this was a controversial issue (Spradlin & Seigel, 1982). Rice (1983) stated cognitive understandings were necessary for language development. Coggins & Morrison (study cited in Wetherby & Gaines, 1982) reported that cognition influenced linguistic structures and linguistic expressions of meaning at an early age. Similarly according to Piaget (1982), the child's cognitive structures provided the basis for the emergence of language as well as other symbolic processes. Casby & Ruder (1983) stated, according to many other researchers, the absence of certain cognitive skills may explain why some children fail to acquire language creating language impairments.

Intervention (therapy goals) for this practicum will follow normal developmental stages for receptive language

skills (Appendix F) since the communication development of normal children's prelinguistic development has been shown to be applicable to the mentally retarded populations communication development (Penner & Faircloth, 1984).

Report of Action

The Speech Videotape Library project was divided into a preliminary stage and three phases: Phase I involved program development, Phase II dealt with instruction, and Phase III consisted of evaluation. The Preliminaries include permission and approval of practicum from ARC and practicum reviewer (July-September, 1984) as well as other approvals and arrangements (See Appendix L).

Phase I (Program Development) consisted of the development of the videotape library (September-January, 1985), Phase II (Instruction) consisted of instructing and training participants (Workshops I and II), as well as the participants viewing the videotape library (November, 1984-May, 1985). Lastly, Phase III (Evaluation) consisted of the evaluation prior to the Speech Videotape Program and after its implementation (May-September, 1984, and May, 1985).

The Preliminaries remained the same as the proposed plan except for the fact that the funding for the videotapes was not acquired through PL 89-313 or ARC. The author assumed this expense. Similarly the Florida Diagnostic Learning Resources Systems (FDLRS) did not participate in videotaping the therapy sessions, workshops or editing; the

author performed all these duties. FDLRS was unable to help since they did not have the equipment to edit VHS tapes. They required ten 3/4 inch tapes which would cost a total of $390. The author was unable to afford this expense and was unable to obtain funding (ARC or PL 89-313). Therefore, the author did all the videotaping and editing as well as paid for all the VHS tapes (20 tapes at $140). Due to this roadblock, an extra two months was necessary to complete the videotaping and editing procedures.

Phase I, development, was therefore extended two months partially due to the fact that the author was not skilled in the area of videotape productions. Originally, the author planned to videotape the children in the ARC infant and preschool programs for the Speech Videotape Library. Although after two months of videotaping and viewing the videotapes it was realized that a mother of a handicapped child may become emotionally upset viewing other handicapped children, especially if the viewer's child was mildly involved or an infant and the videotaped child was moderately or severely involved or an older child. Similarly, if the viewer had not accepted the handicap, then the mother may become emotionally devastated and not wish to view the tapes. It is more difficult to see a handicapped

child progress than a normal child. Furthermore, it is similar to the "thin model syndrome" on television commercials, if you drink the Diet Coke you will look like the model on the screen. Similarly, if you watch an adorable baby achieving the goals on the videotape your baby will improve and begin to look like that. The self-fulfilling prophecy may come into play and the parent will be more motivated to view the videotapes. When this dilemma was posed to the parents at the first workshop, they felt that watching a child with a handicap would give them better suggestions on treatment techniques for their handicapped child. Once the workshop participants learned that their child would, in many instances follow the normal developmental sequences at a different pace (slower), they agreed it would be more beneficial to view normal or mildly involved infants and children accomplishing goals on videotape.

It was very difficult videotaping the children for many reasons. Many of the children did not perform as expected. They became tired, hungry, cranky, experienced stranger anxiety, etc. This required videotaping a session over and over which took the spontaneity out of the child's reactions. In addition, the scheduling of videotaping

sessions ran into the holiday, cold and flu seasons. For this reason videotapes were rescheduled many times. The author's 6 year old son was videotaped acting out some of the goals in order to clarify the teaching techniques on the videotapes; at times the babies did not clearly produce the goals as expected. Although the uncooperativeness or difficulty learning a task by some of the babies was included in the footage as a learning experience of what to and what not to do. These segments were often followed by the 6 year old's performance of the same goals.

Technical difficulties also created setbacks. Often a great session occurred and the video equipment was not hooked up properly or the equipment was not turned on. The videotapes were taken by the author as she was working with a child. The video camera was set on a tripod. Often the author and child were not centered properly or out of focus.

The technical difficulties along with illness, holiday season, as well as expected behavioral problems from the children (tiring quickly, crying, etc.) and changing the population (to normal children or mildly involved children) of children being videotaped created changes in the proposed timetable by two months (See Timetable, Appendix L).

Phase II, instruction, also ran into many difficulties resulting in changes. The eight workshops (two per school) turned out to be 12 workshops. The author ran into the problem of poor parental participation due to the holiday season (Thanksgiving and Christmas) and ill children. Workshop I was therefore presented six times, twice in two of the schools. The first of the series of Workshop I, presented on November 19th (one week prior to Thanksgiving), had the best turnout (12 parents, four teachers, two infant trainers and two social workers = 20 participants). However, the initial presentation of Workshop I in the other three preschools had poor attendance; no one attended in two of the schools (scheduled on November 26 and 27) and two parents attended the November 29th Workshop I. Those workshops scheduled at the beginning of December (Workshops I and II) also had poor parent attendance. For this reason all workshops were rescheduled for the second and third week of January, 1985. This rescheduling increased the parent attendance.

Many of the teachers and teachers' aides at ARC could not attend the workshops scheduled at 10:00 a.m. due to their work responsibilities, therefore the author repeated the workshops in each school at 12:00 during the children's

nap time. Workshop I was repeated a total of seven times and Workshop II was repeated a total of five times. The time frame for viewing the videotapes was changed to January-May, 1985. The videotapes were not ready for viewing until January, due to the problems already discussed and the viewing of the videotapes to determine results was terminated at the end of May due to summer vacations in June and July. However, the videotapes are now being utilized as an educational program for teachers and parents in the ARC infant intervention and preschool programs.

Phase III, evaluation, also underwent many changes. Fifteen children (three from preschool and 12 from the infant program) were chosen for the sample rather than 23 because unfortunately during the implementation, Phase III, two infants died, three relocated, one dropped out of the program and two became very ill (hospitalized frequently).

Of the 15 children used in the sample, eight were planning to leave town for two weeks to three months in June, July and August for the summer and two were relocating as of June 15. Therefore data had to be gathered at the end of May instead of June and July. This changed all the re-evaluation dates on the proposed timetable (Appendix L) from June, and July, 1985, to May, 1985.

The last change in Phase III was the information obtained on the Interactional Analysis Chart (Appendix A) based on four teachers' and four parents' interactions with four children (three of the children were from the ARC infant intervention program and one was from the preschool). The proposal stated five parents', teachers' and children's interactions would be analyzed although one child died during the implementation phase of the speech program.

1. June-July, 1984 - Spoke with reviewer to discuss problem and solution strategy for major practicum.
2. May-September, 1984 - Evaluation of children at ARC who were participating in the Speech Videotape Library Program.
3. June, 1984 - Discussed Speech Videotape Library Program and given approval from Executive Director and Director of Education at ARC.
4. July, 1984 - IBM granted $3,000 to purchase videotape equipment for ARC preschools.
5. July-August, 1984 - Spoke with John Sutton, Learning Resource Specialist at Florida Diagnostic Resources Systems (FDLRS) to obtain information about videotaping and editing procedures. He agreed to videotape and edit the sessions if the author purchased 3/4 inch videotapes and if permission was granted to utilize the studio and equipment at Spanish

River High School. The final outcome was the author was unable to to secure funds for the 3/4 inch tapes, therefore FDLRS was unable to videotape or edit.

6. August, 1984 - Spoke with Dr. Al Peters and Dr. Duretha Long at the Palm Beach County School Board pertaining to securing funds under PL 89-313 for ten 3/4 inch videotapes at $29.00 each. They informed the author there were no funds available for speech programs.

7. August, 1984 - Spoke with presidents of Central and South Palm Beach County Cope groups concerning arrangements to speak about the Speech Videotape Library.

8. August, 1984 - Asked Executive Director of ARC to send letter of thanks to Dr. Pinder, principal at Spanish River High School, thanking him for his cooperation in considering ARC's use of his facilities as a training tool for his audiovisual crew to film the videotapes for the Speech Videotape Library. Letter was sent out August 23 (Appendix J).

9. August-September, 1984 - Developed parent permission slips (Appendix M) and other forms for the speech program (Appendix A-N).

10. August, 1984 - Spoke with Program Director at ARC pertaining to specifics about Speech Videotape Library Program.

11. September 11 - Spoke to Central County Cope group about proposed Speech Videotape Library. The group consists of parents whose children have special needs. The children's ages range from infancy to early adulthood.

12. September, 1984 - Videotape permission slips signed (Appendix M).

13. September, 1984 - Submitted practicum proposal.

14. September, 1984 - Made decisions that videotaping will be conducted by author not John Sutton at FDLRS.

15. September, 1984 - Participants filled out questionnaire (Appendix C).

16. September-October, 1984 - Videotaped parents and teachers in each preschool prior to implementation.

17. End of September, 1984 - Practicum Proposal approved.

18. September, 1984-January, 1985 - Development of videotape library.

19. October, 1984 - Discussed speech videotape library at South Palm Beach County Cope group.

20. November, 1984-January, 1985 - Presentation of 12 workshops.

21. January, 1984-May, 1985 - Participants viewed videotape library and worked with children.

22. May, 1985 - Children were re-evaluated.

23 May, 1985 - Teachers and parents from each school were videotaped to compare with initial videotape evaluation.

24. May, 1985 - Questionnaire after implementation of speech program.

25. May, 1985 - Collection of data.

26. May, 1985 - Writing of Chapter V of Major Practicum.

27. June, 1985 - Approval of Practicum.

CHAPTER V

RESULTS, CONCLUSIONS AND RECOMMENDATIONS

Results/Discussion

The Speech Videotape Library was a success. The success is noted when analyzing all the assessment instruments outlined on Chart I. Parents and teachers have learned to carry out speech goals in the natural and instructional environments. They learned which goals came next developmentally as well as how to simplify a receptive language speech goal. Parents and teachers learned to use more effective and appropriate reinforcers. They were more motivated to work with the children due to the observable gains the children were achieving. The children became eager to learn and all the children made gains in the area of receptive language due to the increase in effective therapy provided by their parent (caregiver) and teachers.

Fifteen children (12 infants and three preschoolers) from the ARC infant intervention and preschool program were utilized to determine the effectiveness of the Speech Videotape Library Program. The program turned out to be a greater success than expected.

According to the results obtained from the observation (See Chart III) of four parents as well as four teachers

carrying out one or two goals with a child prior to and after the implementation of the videotape library, all (100%) teachers and parents learned to use natural reinforcers (defined in Appendix D) when a reinforcer was necessary. The occurrence of verbal, physical, edible and tangible reinforcers decreased by 21% for teachers and 31% for parents. Parents tended to give more physical reinforcers and teachers gave more verbal reinforcers prior to the implementation of the speech program. Whereas, post implementation, teachers revealed a 14% increase in presenting natural reinforcers and a 20% increase in the use of natural reinforcers utilized by parents. The average of teachers' and parents' administration of natural reinforcers equaled a 17% increase in the use of natural reinforcers. They learned when to give the reinforcers as well as when to withhold a reinforcement to approximate a closer response. Thirty percent of all teachers and 38% of all parent's responses, prior to implementation, consisted of providing the child with a reinforcer. The Interactional Analysis Form after implementation showed a decrease of reinforcers by both teachers and parents (7% and 6% respectively).

Parents' and teachers' responses in general increased (16%) after implementation. Interestingly, teachers produced

mostly imitation and modeling (13%) techniques prior to implementation and used basically imitation (12%), expansion (12%), modeling (15%) and direction responses (14%) after implementation. Whereas, parents initially utilized many more non-verbal (11%) and unrelated responses (14%) than teachers. After implementation various teaching techniques were employed: imitation (12%), repetition (12%), expansion (12%), modeling (10%) and direction (8%). Both parents and teachers reduced the production of unrelated responses (12% and 10% decrease respectively). Similarly, children responded with more correct responses (45.5%) after implementation and reduced incorrect responses by 29% and inappropriate responses by 30%.

The results of the Interactional Analysis Charts demonstrated that parents and teachers were successful in carrying out speech goals in the environment they were in (natural and instructional). The criteria for success was to observe 10% increases in parent/teacher responses to 1E, 1-9, and decrease in 10; slightly higher percentages were obtained: 17% increase in 1E responses, 17.5% increase in overall responses 1-9 and an 11% decrease in #10 responses.

The children's success in learning goals was significantly higher than expected, 100% of the children

produced correct responses. The criteria for success was a 10% increase in response #1 whereas a 45.5% increase was achieved. Similarly 10% decreases in #3 and #4 were expected and a 29% and a 30% decrease respectively was obtained (all four children reduced incorrect and inappropriate responses).

All parents and teachers learned how to reinforce appropriate behaviors by using appropriate reinforcers (17% increase in the use of natural reinforcers). This exceeds the 10% increase expected.

The Videotape Library Circulation Form (Appendix B) indicated many interesting findings. The videotapes were utilized by 100% of the sample group, at least five times per child and as many as 15 times. Thirty-eight individuals viewed the videotapes. The viewers consisted of mostly parents and teachers. In addition, there were three grandparents, two aunts and three babysitters. The comments on the form expressed the parents' and teachers' wish to expand the videotape library for children from the ages of birth to six as well as include other developmental areas. Many comments (15) showed that the viewer thought the program was helpful.

The Videotape Library Circulation Form demonstrated

that the children received more therapy since the tapes were viewed at least five times and as often as 15 times per child. More parents (caregivers) than teachers viewed the tapes. Some (six) parents viewed the same segment two times.

The Circulation Form also demonstrated that the parents and teachers were motivated to learn how to teach physically and mentally handicapped children by comments on the forms (I learned how to teach my child; I would like to see some tapes on gross motor ideas, etc.). This motivation was also noted by the number of individuals who viewed the videotapes (38). The parents involved other caretakers to view the videotapes. The criteria of motivating at least ten individuals to view the videotapes was far exceeded (38 viewed tapes).

The Questionnaire (Appendix C) revealed many significant findings when the questionnaire was handed out the first time. There were mostly responses indicating the respondent was unsure or (45% indicated multiple choice #3 and 15% indicated multiple choice #2) did not know. There were fewer (35%) "yes" responses and more (5%) not applicable responses (multiple choice #4 before implementation. After implementation, when the forms were

filled out for the second time, there were 0% #2 responses(did not know), 10.5% #3 responses (not sure and 3% #4 responses (not applicable). Eighty-seven and a half percent of all respondents circled the "yes" response to questions 1-4, 6, 7, 9 and 10. There was a 42.5% increase in "yes" responses.

After implementation, the questionnaire aided in determining if parents and teachers were able to carry out speech goals in the natural and instructional environments by analyzing questions #6 and #7 (Are you confident the speech goals you use are appropriate?; Are you successful in teaching a speech goal?). There was a 55% increase in "yes" responses to question #6 and a 51% increase in "yes" responses to question #7. This is significantly higher than the 10% expected increase for criteria of success.

When determining if parents and teachers learned to progress to the next developmental goal, question #2 (Do you know which goal to work on next?) was examined. There was a 44% increase in "yes" responses to question #2 after implementation. Once again this percentage was 34% higher than the expected criteria for success. Therefore the videotape library program was successful in carrying out this goal.

Similarly, the second administration of the questionnaires (after implementation) showed a 62% increase in "yes" responses to question #4 (Do you know how to breakdown a long term goal?). This demonstrated that parents and teachers learned to simplify goals. Furthermore, the questionnaire demonstrated that parents, teachers and children became more motivated to learn and perform speech goals after implementation. This was noted by analyzing questions #7, #8, and #9 (7. Are you successful in teaching a speech goal?; 8. Who should teach speech goals?; 9. Do you feel you are successful in motivating a child to learn?). The criteria for success was a 10% increase in "yes" responses for #7 and #9 and 50% select response four in question #8. The parents and teachers responded with a 51% increase in "yes" response to question #7, a 41% increase in "yes" responses to question #9 and furthermore, 100% of the respondents selected #4 (all of the above) for question #8.

There was a 48% increase of multiple choice five to question #10 (type of reinforcer) after implementation. This far exceeded the expected criteria of success (10%) after implementation of the Speech Videotape Library Program.

Thirty (100%) Recording Forms (Appendix E) were filled in (15 teachers and 15 parents) during the implementation of

the Speech Videotape Library Program. The recording form showed that 100% of parents and teachers progressed to the next developmental goal after the first goal was accomplished. Therefore, the videotape library program was successful in teaching parents and teachers how to determine which goal is next.

An analysis of the Recording Form also demonstrated that the goal to provide children with more therapy was also a success. The expected criteria for the success of this goal was that at least one date per month would be recorded on the form. It turned out that all (100%) the teachers (15) and parents (15) recorded at least one session per month and as many as 20 sessions appeared on 20 of the Recording Form. All the teachers and five parents recorded goals and progress weekly.

When a goal was not accomplished after two weeks, nine teachers and six parents (15) simplified the goal until it was easily accomplished by the child. Therefore 50% of the 30 who filled out the Recording Form were able to simplify goals. This demonstrated that the goal to simplify receptive language speech goals was a success.

Lastly, the completed Recording Forms demonstrated that children progressed in the area of receptive language.

One hundred percent of the children (15) accomplished two or more goals in a period of five months.

The developmental scales utilized, The Sequenced Inventory of Communication Development (SICD), Early-LAP and the Alpern-Boll Developmental Profile (receptive language sections) indicated that all the children (100%) progressed in the area of receptive language. The criteria for success was that all children would progress to the next developmental level on the developmental scales utilized. This occurred with all 15 children when using the Alpern-Boll and Early-LAP since the progression is at two and one month intervals respectively. Although this did not occur on the SICD, since it requires the child to progress four months in order to reach the next level of development on this scale. One child progressed only two months in a five month period of time, although the other 14 children progressed between four to eight months in a five month period. Therefore the videotape library program was successful at teaching children receptive language skills (93% progressed to the next level of development on all the scales).

It was possible to compare four children's rate of progress prior to implementation of the speech program and

following implementation of the speech program on two evaluation tools (SICD and Alpern-Boll, see Chart II). Three children progressed at a faster rate after the implementation of the speech program and one progressed at the same rate prior to and after implementation.

When examining Chart's I, II and III one can see the degree of success of the Speech Videotape Library.

Many unexpected outcomes arose as a result of the Speech Videotape Library Program. The most important was the interest of parents of the normal infants and preschoolers who wanted to make use of the videotape library. These parents were amazed that their children were able to accomplish goals that they did not even think of introducing, i.e. identify objects, follow simple directions, etc. at their young age as well as the ease (how quickly) at which they learned a new goal. Most of the parents of the normal infants admitted that they did not know the order of normal speech development and would like to view the tapes to help them identify this order, this would prepare the parent for what was to come next, and learn how to teach their child the next goal. The author allowed two parents (of normal children) to use the videotape library but cautioned them not to go too quickly

and make sure the child truly accomplished one goal before progressing to the next. As a result the two normal babies progressed four months in a two month period of time according to the results on the SICD. The author received several calls from parents of normal babies to view the tapes during and after the implementation of the videotape library.

Another outcome was that the 15 parents and teachers in the program asked many questions at the beginning of the implementation phase; such as, how to simplify a goal, how to fill out a form, how to achieve a goal, (techniques) etc. The author was not asked any questions during the last four months of implementation instead teachers and parents were eager to demonstrate the child's successes. This eased the workload a little and allowed the speech pathologist to construct language systems for several children (Hall & Klein, 1983).

Parents of the handicapped children began utilizing techniques learned (i.e. reinforcements, techniques, simplifying goals, etc.) with normal siblings. They reported the success they saw.

The author found the videotape library had a greater impact with the parents than the teachers. The parents expressed more excitement about the accomplishments their children made. This may be attributed to the fact that the

parent was more emotional about their own child and did not have any previous training in teaching skills as the teaching staff did. The parents' self-esteem was elevated by being trained and evaluated in the same manner as the teachers. They felt like an equal and a colleague rather than inferior as they often do in a school system. The parents and teacher aides were as effective in teaching as supervising teachers.

Progress was noted in related developmental areas such as expressive language and cognitive areas on the Hawaiian Early Learning Profile (HELP). Teachers noticed the 15 children in the program progressed faster in these areas than the other children in the school. Similarly, the speech pathologist saw improvement in the children's expressive language during informal observations as well as improved results on the expressive scale of the SICD. Meisel (1984) reported similar findings, early intervention produced positive effects in other areas. If this program continues it is the author's feeling that these children will need less intervention or specialized programs as they get older (Marge, 1984).

It was noted on the Videotape Library Circulation Form (Appendix B) that five of the 15 parents had their own

videotape equipment. The others viewed it in friend's or relative's homes or at school. At the end of the implementation phase, 12 parents had their own videotape equipment. The parents saw the importance and versatility of such equipment.

Parents and teachers in a nearby public school (Royal Palm) for the physically and mentally handicapped child asked questions and expressed an interest in the Speech Videotape Library Program. They found out about the program from parents in the ARC infant program and preschool.

There has been an increase in parent participation at parent coffees, Cope group meetings, inservices and presentations in the community. Some (four) parents have expressed to the author a need to learn as much as they could from professionals.

The videotapes of the workshops are presently being used as inservices for new staff members and parents (Carpenter, 1979), staff turnover is a common occurrence at ARC due to low salaries and families relocating for better employment opportunities. Therefore, videotapes are being used as instructional aids to train new teachers at ARC. This is a successful and time and cost effective procedure.

CONCLUSION

The author has concluded that the Speech Videotape Library was successful. A greater success than anticipated was obtained. Seven goals were accomplished (see Chart I) according to the results of the evaluation instruments utilized. One hundred percent of the children in the sample group at the ARC preschool and infant intervention program have progressed in the area of receptive language as well as in other related areas. They became more motivated to learn and received more intense therapy (at least five times per week). Lovaas, et al., (study cited in Hall & Klein, 1983) suggests that progress in a particular area of development may be related to the concentrated therapy due to more extensive parental involvement. One hundred percent of the teachers and parents became more effective and motivated teachers. This is similar to Frith & Teller (1982) and Shinn-Strieker's (1982) findings that parents as well as paraprofessionals can be effective in teaching infants and preschoolers. They all learned how to carry out receptive language speech goals in either natural environments (at home) or instructional environments (at school). These techniques were generalized and appropriately used to work with other children at home or in school. Teachers and

parents became more motivated to work with the children when they saw the progress the children made recorded on Appendix E (Sandler, 1983). Parents were as successful as teachers in teaching children new goals (Arnold, Sturgus & Foreland; Baker, et al; Baker & Heifetz, studies cited in Hall and Klein, 1983).

Fifty percent of the parents and teachers learned how to simplify goals; this in turn motivated children and teachers since progress became observable. The parents and teachers learned to identify when a goal was accomplished and how to progress to the next developmental goal. Lastly, 100% of the teachers and parents learned which were the most effective reinforcers and began to reinforce children less often. They began expecting and shaping more refined behaviors before the child was reinforced.

The videotape equipment was successful as an evaluative tool, and (videotaped parents/teachers interacting with a child before and after implementation of speech program) instructional tool (teach parents and teachers therapy techniques and normal development). Other authors have found similar success with videotapes used in a similar manner (Butler, 1974; Hoerner, 1972; Lemmer & Drake, 1983; Boone; 1970; Estus, et al, 1980; Flahive, 1976). It

- was time and cost effective and found to be a better and more practical teaching technique than observations or lecture because of its convenience; it can be viewed over and over, is less threatening and not necessarily boring if edited properly.

RECOMMENDATIONS

The following recommendations will benefit others who plan to teach parents, teachers and paraprofessionals of exceptional infants and preschoolers as well as plans for furthering the solution described previously.

1. It is suggested that one has help, an extra set of hands to operate the video camera. It will save time in the long run. Much of the author's footage was out of focus or not centered when operating the camera by remote since the author was being taped and working the camera simultaneously.

2. Young children, birth to four years, should not be scheduled to be videotaped for a program or project during the months of December through April. This is the holiday season as well as the cold and flu season. Similarly, workshops should not be scheduled during November, December, June, July and August. These are the holiday seasons and vacation time.

3. When videotaping a child's behavior, if you cannot get it after the second try, move on to another goal or activity and come back to the first one at another time or day. Physically handicapped children, as well as any young child may fatigue quickly or they may not cooperate very

long. The first ten minutes will be a good representation of their best behavior. Therefore one must be organized and know exactly what one is trying to get and how to get it. Time is of the essence.

4. The author has concluded that it is best to start a research project or study during late summer (preliminaries) and end by May in order to avoid holiday seasons, illnesses and vacation time.

5. Carefully compute expenses needed prior to starting a research project including all hidden costs (photo copies, videotapes, travel expenses, phone calls, etc.) as well as time to spend on project. Plan time wisely and try to secure funding prior to research project if necessary and possible.

6. The author plans to continue the Speech Videotape Library during the next two years. It will include receptive and expressive language skills from birth to six years. A proposal to secure money for its completion has been completed and a curriculum has been developed.

DISSEMINATION

The author plans to present findings of the Speech Videotape Library to the parent Cope Groups in North, Central and South Palm Beach areas, conferences dealing with speech and/or retardation as well to other Nova doctoral students. The author will utilize parts of the program to teach graduate speech students at Nova University as well as inform them of the program and results. This practicum report will be submitted to the ERIC Clearing House on Handicapped and Gifted Children. In this way the information from this practicum will be made available to a large group of interested individuals.

REFERENCES

Alpern, G. D., & Boll, T. J. Developmental profile manual. Indiana: Psychological Development Publications, 1972.

Area Planning Board of Palm Beach County (the), 1982, 16(1).

Billeaud, F. The use of videotape recordings to teach clinical skills (evaluation and remediation) in the fields of communicative disorders. Lafayette, Lousiana: University of Southwestern Louisiana, 1976. (ERIC Document Reproduction Service No. ED122789)

Boone, D. R., & Stech, E. R. The development of clinical skills in speech pathology by audiotape and videotape self-confrontation. Final report. Denver, Colorado: Denver University, 1970. (ERIC Document Reproduction Service No. ED042366, Abstract).

Brigance, A. H. Brigance diagnostic inventory of early development. Mass: Curriculum Associates, Inc., 1978.

Burnell, D. P. Videotape replay: Positive reinforcement in behavioral modification with the adult retardate. Final report. Berkeley, Calif.: National Center for Educational Research and Development, 1972. (ERIC Document Reproduction Service No. ED066057, Abstract)

Butler, K. Videotaped self-confrontation. Language Speech & Hearing Services in Schools, 1974, 5(3), 162-170.

Carpenter, R. L. Closed circuit interactive television and inservice training. Exceptional children, 1979, pp. 289-290.

Casby, M., & Ruder, K. Symbolic play and early language development in normal and mentally retarded children. Journal of Speech and Hearing Research, 1983, 26(3), 404-411.

Committee on Language, Speech, and Hearing Services In The Schools. Guidelines for caseload for speech-language services in the schools. American Speech-Language-Hearing Association, 1984, 24(4), 53-58.

Committee on language, speech, and hearing services in schools. American Speech-Language-Hearing Association, 1984, 26, 53-57.

Committee on Prevention of Speech and Hearing Problems Prevention: A challenge for the profession. American Speech-Hearing-Language Association, 1984, 26(8), 35-37.

Connor, F. P., Williamson, G. G., & Jiepp, J. M. (Eds.) Program guide for infants & toddlers with neuromotor & other developmental disabilities. New York: Teachers College Press, 1978.

Creekmore, W., & Creekmore, N. Senior citizens as paraprofesionals in teaching severely handicapped children. Exceptional children, 1983, 49(5), 455-457.

Estus, L., et al. Videotaping as a supervision tool. Teaching young children with special needs. Boston, Mass.: Wheelock Coll. (ERIC Document Reproduction Service No. ED202800, Abstract).

Fadiman, A. Radical new methods of healing the fetus, the unborn patient. Life, April 1983, pp.39-44.

Fein, D. J. The prevalence of speech and language impairments. American Speech-Language-Hearing Association, 1983, 25, 37.

Flahive, M. Videotape trains trainers of the mentally retarded. Educational and Industrial Television, 1976, 8(6), 28-31.

Frith, G. H., & Teller, H. E. Using paraprofessionals in programs for hearing-impaired children: A discussion of roles. Language Speech & Hearing Services in Schools, 1982, 13(3), 172-176.

Furuno, S., O'Reilly, K., Hosaka, C., Inatsuka, T., Allman, T., & Zeislott, B. Hawaiian early learning profile (HELP). Palo Alto: VORT Corporation, 1979.

Garner, R., Lacy, G., & Creasy, R. Workshops, why, what, whither? Mental Retardation, 1972, 10(3), 25-27.

Glover, M. E., Preminger, J. L., & Sanford, A. R. The early learning accomplishment profile for developmentally young children birth to 36 months. N.C.: Kaplan Press, 1978.

Griffin, P., & Sanford, A. Learning accomplishment profile for infants (LAPI). North Carolina: Kaplan Press, 1978.

Hall, M. K., & Klein, M. D. A home-centered instructional communication strategy for severely handicapped children. Journal of Speech and Hearing Disorders, 1983, 48(1), 2-10.

Hedrick, D. L., Prather, E. M., & Tobin, A. Sequenced inventory of communication development examiners manual. Washington: University of Washington, 1979.

Inservice programs in learning disabilities. A position paper of National Joint Committee on Learning Disabilities, September 1981.

Irwin-Carruthers, S. H. Results of early intervention in the baby with cerebral motor disturbance. Physiotherapy, June 1981, pp. 34-37.

Jonas, R. K. Feeders of physically handicapped infants and preschoolers. Manuscript accepted for publication, 1984. (ERIC Reproduction Service)

Leith, W., Braun, S., Ajango, N., Fichter, G., & Everett, J. A cooperative training program for public school speech clinicians. Language, Speech & Hearing Services in Schools, 1974, 5(3), 156-61.

Lemmer, E. C. J., & Drake, M. L. Client management professional development: A student training cycle. American Speech-Language-Hearing Association, 1983, 25, 33-39.

Marge, M. The prevention of communication disorders. American Speech-Language-Hearing Association, 1984, 26(8), 29-33.

McCracken, A. Drool control and tongue thrust therapy for the mentally retarded. The American Journal of Occupational Therapy, 1979, 32(2), 79-85.

McDade, H. L., & Simpson, M. A. Use of instruction modeling, and videotape feedback to modify parent behavior: A strategy for facilitating language development in the home. Seminars in Speech and Language, 1984, 5(3), 229-240.

McKay, A. Longitudinal study of the long term effects of the duration of early childhood intervention on cognition ability and primary school. Unpublished manuscript, Northwestern University, 1983.

Meisels, S. Early childhood: Issues in assessment and efficacy. Paper presented at the Nova University Ed.D. Program in Early Childhood Summer Institute, Florida, July 1984.

Morlan, D., et al. Television and parent education: An educational revolution. Anaheim, California: Presented at annual meeting of the Association for Education Comunications and Technology (ERIC Document Reproduction Service No. ED122844, Abstract).

Morris, S. E. The normal acquisition of oral feeding skills: Implications for assessment and treatment. New York: Therapeutic Media, In., 1981.

Morris, S.E. Pre-speech assessment scale: A rating scale for the measurement of pre-speech behaviors from birth through two years. N.J.: J.A. Preston Corp., 1982.

Moyer, I. D. Responding to infants. The infant activity manual 6-30 months (RTI), Minneapolis: T. S. Dennison & Co., Inc., 1983.

Penner, K. A., & Faircloth, B. H. The profoundly mentally handicapped: Basing our programs on the state-of-the-art in speech/language pathology and normal language development. Florida Language, Spee ch & Hearing Association Journal, 1984, 5, 16-21.

Piaget, J. Play, dreams, and imitation in childhood. New York: Norton & Company, 1982.

Reilly, A. P., & Stark, R. E. The communication game. Baltimore: Johnson & Johnson Baby Products Co., 1980.

Rice, M. L. Contemporary accounts of the cognition/language relationship: Implications for speech-language clinicians. Journal of Speech and Hearing Disorders, 1983, 48, 347-359.

Russo, J. B. & Owens, R. E. The develoment of an objective observation tool for parent-child interaction. Journal of Speech and Hearing Disorders, 1982, 47(2), 165-173.

Sandler, A., Coren, A., & Thurman, S. K. A training program for parents of handicapped preschool children: Effects upon mother father and child. Exceptional children, 1983, 49(4), 355-358.

Shinn-Strieker, T. K. Trainied communication assistants in the public schools. Language Speech & Hearing Services in Schools, 1984, 15(2), 70-75.

Siegel-Sadewitz, V., & Shprintzen, R. The relationship of

communication disorders to syndrome indentification. Journal of Speech and Hearing Disorders, 1982, 47, 338-354.

Spradlin, J., Seigel, G. M. Language training and clinical environments. Journal of Speech and Hearing Disorders, 1982, 47(1), 2-6.

Striffler, N., et al. Comparison of audiovisual and traditional methods for teaching language concepts to retarded children. District of Columbia: 1977. (ERIC Document Reproduction Service No. ED163692, Abstract).

Sutton, J. Personal communication, July 30, 1984.

Travers, B. Improving speech and language services through effective time and management. Language Speech and Hearing Services in Schools, 1983, 14(2), 86-91.

Videcor, end of project report. Fresno City Unified School District, Calif. Office of Planning and Research Services, June 30, 1972. (ERIC Document Reproduction Service No. ED079963, Abstract)

Vulpé, S. Vulpé-assessment battery (2nd ed.). Canada: National Institute on Mental Retardation, 1979.

Wetherby A. M., & Gaines, B. H. Cognition and language development in autism. Journal of Speech and Hearing Disorders, 1982, 47(1), 63-70.

APPENDIX A

INTERACTIONAL ANALYSIS CHART

APPENDIX A

Interactional Analysis Chart

	CATEGORY	EVENT										TOTAL
		1	2	3	4	5	6	7	8	9	10	
P	1. Reinforcement											
A	A. Verbal											
R	B. Physical											
E	C. Edible											
N	D. Tangible											
T	E. Natural											
/	2. Imitation											
T	3. Repitition											
E	4. Expansion											
A	5. Comment											
C	6. Question											
H	7. Model											
E	8. Direction											
R	9. Non-verbal Response											
	10. Unrelated Response											

C	1. Correct response											
H	2. Approximate Response											
I	3. Incorrect Response											
L	4. Inappropriate Response											
D												
		1	2	3	4	5	6	7	8	9	10	

APPENDIX B

VIDEOTAPE LIBRARY CIRCULATION FORM

APPENDIX B

Videotape Library Circulation Form

One videotape at a time may be borrowed. It must be returned within three days in order to make it possible for others to share and profit from the use of the Videotape Library. Please fill out this form regardless if the tape is taken out of the school or viewed at the school. Thank you for your cooperation.

DATE IN/OUT	TAPE NO.	NAME OF ORGANIZ	CHILD NAME	PARENT	TEACHER	VIEWED			PURPOSE	COMMENTS
						SCHOOL	HOME	OTHER		

BEST COPY AVAILABLE

APPENDIX C

QUESTIONNAIRE

APPENDIX C
Questionnaire

___ ___ ___ ___
last four digits of
Social Security number

_____
school and/or program
child attends

Please check one of the following:
Parent _____ Teacher _____ Other (specify) ____

Please circle one number per question:

1. Are you confident the speech goals you are teaching are the appropriate ones for the child or children you work with?
1. yes 2. no 3. not sure 4. not applicable

2. Do you know which goal to work on next?
1. yes 2. no 3. not sure 4. not applicable

3. Do you know whether or not the child has accomplished the goal you taught?
1. yes 2. no 3. not sure 4. not applicable

4. Do you know how to breakdown a long term goal (one year goal) into smaller steps (three to six month goal)?
1. yes 2. no 3. not sure 4. not applicable

5. How long have you been working on speech goals with the child or children you work with?
1. 0 months 2. 3-6 months 3. 6 months-1 year
4. more than one year

6. Are you confident the techniques you used to teach speech goals are the appropriate ones?
1. yes 2. no 3. not sure 4. not applicable

7. Are you successful in teaching a speech goal?
1. yes 2. no 3. not sure 4. not applicable

8. Who should teach speech goals?
1. parent 2. teacher 3. speech therapist
4. all of the above

9. Do you feel you are successful in motivating a child to learn?
1. yes 2. no 3. not sure 4. not applicable

10. What type of reinforcers do you use to reward the chld for his or her appropriate responses?
1. food 2. praise 3. physical (hug) 4. non-edible object 5. something directly related to response
6. a combination

APPENDIX D

DEFINITION OF TERMS ON INTERACTIONAL ANALYSIS CHART

APPENDIX D

Definition of Terms on Interactional Analysis Chart

Strategy	Definition	Source (cited in Russo & Owens, 1982)
I.Reinforcement	An activity or response that follows a behavior and increases the frequency of that behavior (reinforcer used may be combination of reinforcements below, i.e. cookie given on request is an example of both natural and edible reinforcement).	Boyd & Bluma,1977; Gelman & Shatz,1977; Hess & Shipman,1976; Moerk, 1977; Nelson, 1973.
a.Verbal	A spoken message such as "good", "good work", "great job", etc.	
b.Physical	A physical response such as smiling, hugging, touching, etc.	
c.Edible	Child is given something to eat or drink, etc., for correct response.	
d.Tangible	Child is given non-edible object for correct response.	
e.Natural	Child is given object or shown action which is directly related to his/her correct response.	
II.Parent/Teacher Response (Facilitator's Response)		
a.Imitation	The exact or partial, immediate, noncued repetition of utterance or actoric act of the partner.	Cross, 1977; Nelson, 1973; Slobin, 1973.
b.Expansion	Immediate repetition of word order used by facilitator, but making it more grammatically complete.	Brown & Bellugi, 1964; Cross, 1977; Nelson, 1973; Schumaker, 1976.
c.Direction	The facilitator directs the child to perform a task by direct request.	Baldwin & Baldwin, 1973; Bruen, 1972; Buium, Rynders & Turnure, 1974.
d.Comment	The facilitator comments or makes a statement about the child's response.	
e.Repitition	The facilitator repeats the directions to obtain a response.	
f.Non-verbal	The facilitator directs the child's attention to an object or event without vocalizing. This includes pointing, directing visual gaze towards an object/event, marking an object/ event by exaggerated movement of that object/ event. Facial expressions, gestures, body language may be utilized in place of or accompany verbal message.	Bruner, 1975; Collis, 1975; Mahoney & Seely, 1976; McLear & Snyder-McLean,1978; Bloom, 1970; Dore, 1975.

BEST COPY AVAILABLE

Strategy	Definition	Source (cited in Russo & Owens, 1982)
g.Unrelated Response	The facilitator responds verbally or nonverbally to the child which is not associated to or related to the child's response to the task i.e. facilitator hears the telephone ring and says "I hear the telephone", etc.	
h.Modelling	The verbal or nonverbal modelling of a desired response, such as "Say baby" or "Do this".	Moerk, 1976
i.Question	The use of questions such as "What's this", "What is it?"; yes/no type "Are you happy?"; as well as other "Wh" questions "Where is the baby?"	
III.Child's Response		
a.Correct Response	The child responds appropriately to the facilitator.	
b.Approximate Response	The child's response is close to the expected response. The correct response may be emerging i.e. if response is to turn to sound and child's eyes look in direction of sound, then this is an approximate response.	
c.Incorrect Response	The response is not what is expected. The child is to turn to sound and instead ceases activity.	
d.Inappropriate Response	Child did not respond appropriately i.e. self-stimulating behaviors were elicited (head-banging, screaming, etc.)	

BEST COPY AVAILABLE

APPENDIX E

RECORDING FORM

APPENDIX E

Recording Form

Please check one:
Parent _____ Teacher _____ Other (specify) _____

Date	Goal(s)	Date Accomplished	Not Accomplished This Session (X)

BEST COPY AVAILABLE

APPENDIX F

RECEPTIVE LANGUAGE DEVELOPMENT

(BIRTH TO ONE YEAR)

Appendix F

Receptive Language Development

Age in Months	Behaviors	Sources
0	Notices faces of others	Brigance
0-1	Quiets or startles to loud sound	Early-LAP, LAPI, HELP, 0-3
0-2	Quiets to face	Brigance, LAPI
	Quiets when approached by sound	0-3
	Quiets cry when spoken to	Vulpe'
0-3	Responds to voice	HELP, Early-LAP
0-4	Quiets, moves, or vocalizes to soft sounds	0-3, Vulpe'
1-2	Discrimination of adult voices	Vulpe'
	Wants vibratory sound reproduced	Coss. Sase, 0-3
1-4	Responds to angry voice with frown or pout	Brigance
	Anticipatory reactions	HELP, Early-LAP
2-3	Looks directly at speaker's face	0-3
	Reacts to disappearance of slowly moving object	HELP, Coss. Sase
	Use body parts to produce sounds (tongue click, lip smack, bang legs)	0-3
	Associates particular sound with specific activities (door with doorbell)	0-3
	Searches with eyes for sound	HELP
3-4	Explores objects and the environment with hands and mouth	HELP
	Turns eyes and head to sound of hidden voice	HELP, 0-3, SICD, Vulpe',Early-LAP
	Awakens or quiets to mother's voice	HELP
	Turns and visually locates source of sound	SICD, 0-3,Vulpe'
4-5	Independently causes a sound to occur through a motor act (hitting a bell, pressing squeak toy)	0-3
5-6 1/2	Distinguishes between friendly and angry voices	HELP
	Shows recognition of name	Brigance, 0-3, LAPI, Vulpe'
	Recognizes familiar words	Early-LAP RTI,Vulpe',SICD, 0-3, HELP, Early-LAP
6-7	Understands familiar phrases without accompanying gesture	Vulpe', HELP, SICD, Early-LAP
	Understands less familiar phrases if accompanied by gestures	Brigance
	Knows the names of family members	Vulpe'
	Reacts to music or singing	SICD, Vulpe'
		Vulpe'

BEST COPY AVAILABLE

BEST COPY AVAILABLE

Age in Months	Behaviors	Sources
7-8	Indentifies common objects	SICD, Vulpe'
	Listens to conversation of others	Vulpe'
	Understands simple questions	Brigance, 0-3, SICD
	Understands "no"	Vulpe'
	Interested in looking at pictures named in a book	HELP
	Understands gestures for yes, no, bye-bye	HELP, Vulpe ,
	Understands a wide range of words	SICD, HELP
9-10	Understands "don't touch" when spoken by unfamiliar person	Vulpe'
	Listening to new words and conversation	Vulpe'
	Attention to speech in the presence of auditory distraction	HELP
	Follows simple directions (stand up, give me, come here)	SICD, Vulpe'
	Localizes and fixes gaze on sounds to sides and below	0-3
10-11	Understands one preposition (in, on, or under)	SICD, Vulpe', Early-LAP
	Understands plurality	Vulpe', SICD
	Understands adverbs (fast, slow)	Vulpe', SICD
	Imitates gross motor gestures (clap hands, peek-a-boo)	SICD, HELP, RTI
	Rhythmic response to music	Vulpe', HELP
11-12	Prolonged attentiveness (several minutes) to speech	Vulpe'
12-14	Increasing understanding of new words weekly	Vulpe'
	Listens to rhymes and jingles	Vulpe'
	Points to pictures of familiar objects	SICD, HELP, Vulpe',Early-LAP
	Recognizes acquaintances other than family members	SICD, HELP
	Understands familiar nouns (doll, car, book, daddy, etc.)	Vulpe', 0-3, SICD, Coss, Bzoc

APPENDIX G

OUTLINE OF WORKSHOP I

APPENDIX G

Outline of Workshop I

I. Broad Overview of the Speech Videotape Program

A. Purposes

1. the advantages

2. the disadvantages

3. the expected outcome

4. evaluation techniques

II. Receptive Language Development

A. Birth to One Year (Summarized in Appendix E)

III. Natural Environment versus Instructional Environment

A. Spradlin's and Seigle's (1982) Recommendations for These Two Environments

IV. Attending Behaviors

V. Reinforcement Schedules (See Appendix E)

A. Verbal Reinforcement

B. Physical Reinforcement

C. Edible Reinforcement

D. Tangible Reinforcement

E. Natural Reinforcement

APPENDIX H

OUTLINE OF WORKSHOP II

APPENDIX H

Outline of Workshop II

I. Review of the Speech Videotape Library Program

A. Distribute Handout of Goals Recorded on the Videotapes

II. How to Use the Videotape Library and Equipment

A. How to Locate the Tape and Segment of the Tape Needed for Your Child

B. Discussing the Procedures for Borrowing the Videotape (Appendix B)

III. How to Incorporate the Videotape Into the Environment or Situation the Child Is In

IV. How Do You Know When a Child Accomplishes a Goal

V. Recording a Child's Progress (Appendix J)

VI. How Do You Know Which Goal Comes Next.

VII. How to Breakdown Goals Into Smaller Steps In Order to Allow the Child to Succeed

APPENDIX I

INVITATION TO WORKSHOP

APPENDIX I

Invitation to Workshop

You are invited to attend a speech workshop at the ARC preschool (name of preschool)_____ on (date/time) _____ The topic will be a videotape library technique to train teachers, parents and others interested in carrying over speech goals established by the speech-language pathologist.

Please come! Thank you for your cooperation and interest.

Sincerely,

Renai Jonas
Speech-Language Patholgist

APPENDIX J

LETTER TO PRINCIPAL

arc
Association for Retarded Citizens
Palm Beach County

1201 Australian Avenue
Riviera Beach, Florida 33404

305 842-3213

APPENDIX J

Letter to Principal

Burt Reynolds
Honorary Chairman
Bernard R. Baker III
President
Joyce W. Laird
Executive Director

August 23, 1984

Dr. William Pinder, Principal
Spanish River High School
5100 Jog Road
Boca Raton, Florida 33434

Dear Dr. Pinder:

On behalf of the Association for Retarded Citizens, I want to thank you for exploring the feasibility of allowing our speech consultant, Renai Jonas, to use the facilities at Spanish River High School for the video taping of thirty speech modules.

These speech modules will be used to train parents and teachers who, in turn, will be working with mentally retarded and physically handicapped preschool children. These modules will become part of a library which will benefit many individuals in the community, the Palm Beach County School Board and the Association for Retarded Citizens. We expect that the modules will also be used as a training course for the media students at Spanish River High School.

The studio and equipment at your school will afford us the opportunity to produce high quality videotapes with the aid and cooperation of Barbara Outland and John Sutton, the Learning Resourse Specialist at FDLRS.

Thank you for your efforts.

Sincerely,

Joyce W. Laird
Executive Director

JWL/tc

A United Way Agency

Branch Office Suite 30
500 E. Spanish River Blvd.
Boca Raton, FL 33431 • 391-1504

APPENDIX K

LIST OF GOALS ON VIDEOTAPE

Appendix K

List of Goals on Videotape

Tape#/Footage	Goals	Sources
	1. As person comes into line of vision and talks, child will respond with momentary glance	Brigance
	2. Stops crying and shows active interest for at least one minute when someone enters room	Brigance, LAPI, HELP
	3. Quiets or startles to loud sound of a rattle or bell	Early-LAP, 0-3,RELA, HELP, LAPI
	4. Quiets, moves, or vocalizes to soft sounds	Vulpe', 0-3
	5. Activity arrests when approached by sound	0-3
	6. Responds to friendly voice and fondling with smile or coo	0-3, Early-LAP,LAPI, Brigance
	7. Listens to voice for 30 seconds	HELP
	8. Increases activity to attend to unfamiliar voices	0-3
	9. Increased activity, vocalizations, or facial expressions when a talking person approaches child	HELP, Early-LAP
	10. Watches speaker's eyes and mouth	HELP, Early-LAP
	11. Movements indicate the desire for vibratory sound to be reactivated (i.e. drum)	0-3, Comm. Game
	12. Reacts to disappearance of slowly moving object by vocalizing, ceasing activity or movement	HELP, Comm.Game
	13. Associates a sound to an action or object, i.e. when hears knock looks toward door	0-3, Brigance
	14. Frowns, pouts, or cries in response to an angry voice	
	15. Looks for sound with eyes	HELP
	16. Uses hands and mouth for sensory exploration of objects	HELP
	17. Turns eyes and head to sound of hidden voice	0-3, HELP, Vulpe' SICD, Early-LAP
	18. Awakens or quiets to mother's voice	HELP
	19. Turns to right or left appropriately to visually search for sound source (bell, rattle, etc.)	HELP, SICD, Vulpe'
	20. Responds facially and/or vocally to friendly or angry voices	HELP
	21. Looks up, vocalizes, smiles, maintains eye contact or shows some sign of recognition of name	Vulpe', LAPI, 0-3
	22. Actively or independently cause a sound to occur through a motor act (e.g. tap happy apple, hit bells, etc.)	0-3, HELP
	23. Look at, or gesture toward the appropriate object upon hearing the name of the object	Vulpe', SICD, 0-3 HELP
	24. Responds to familiar phrases without accompanying gesture (i.e. come here, don't touch)	Vulpe', SICD, Early-LAP, Brigance
	25. Understands less familiar phrases if accompanied by gestures i.e., accompany good-bye with hand wave	Vulpe'
	26. Looks at or visually search for a named family member or pet	Vulpe', SICD
	27. Looks toward the source, smiles, laughs, head bobbs or other body movements in response to music or singing	Vulpe'

BEST COPY AVAILABLE

Tape# Footage	Goals	Source
	28. Localizes the sound of a bell or rattle held three feet behind the left or right ear by turning and looking at sound source	Vulpe', HELP,0-3, SICD
	29. When presented with two familiar objects, will look at object named (i.e. ball, dog)	SICD, RTI, Vulpe'
	30. Attends to briefly or the whole conversation of others in the same room	Vulpe'
	31. Responds appropriately to simple questions i.e. "Where is mommy?"	SICD, 0-3, Brigance
	32. Ceases activity to command "no" or "no no"	Vulpe', Early-LAP
	33. Looks at a familiar picture named for at least 1 minute	HELP, Vulpe'
	34. Shows understanding of gesture language by nodding for "yes", shaking head for "no" or waving for bye-bye	Vulpe', HELP
	35. Ceases or activity when told "don't touch" by an unfamiliar person	SICD, Vulpe'
	36. Listens with enjoyment to new words and conversation of others	Vulpe'
	37. Listens to speech of others in the presence of distracting sounds (music, conversation)	Vulpe', HELP
	38. Responds to simple verbal directions such as "stand up", "close the door", "give me"	SICD, Vulpe'
	39. Localizes and fixes gaze on sound source to either side or below	0-3
	40. Responds appropriately at least once to one preposition i.e. "Put the car in, on or under the box."	SICD, Vulpe', Early-LAP
	41. Responds appropriately to "put car in the box" and "put the cars in the box" when presented with 5 cars	SICD, Vulpe'
	42. Responds appropriately to adverbs fast and slow ("Make the car go fast", "Make the car go slow")	SICD, Vulpe'
	43. Imitates clapping hands, rolling a ball, stacking blocks, or playing peek-a-boo, (gross motor imitation)	SICD, RTI, HELP
	44. Responds to music in a rhythmical manner (i.e., nod head, clap hands, move body) without the help of gestures	HELP, Vulpe'
	45. Remains attentive to speech for several minutes	Vulpe'
	46. Attends to spoken rhymes or jingles for at least 3 minutes	Vulpe'
	47. Points to picture of familiar objects named	Vulpe', HELP, SICD
	48. When presented with several familiar objects, child will give or look at the one named	Vulpe', Comm. Game, SICD
	49. Recognizes acquaintances other than family members by looking at or visually searching on request	HELP, SICD

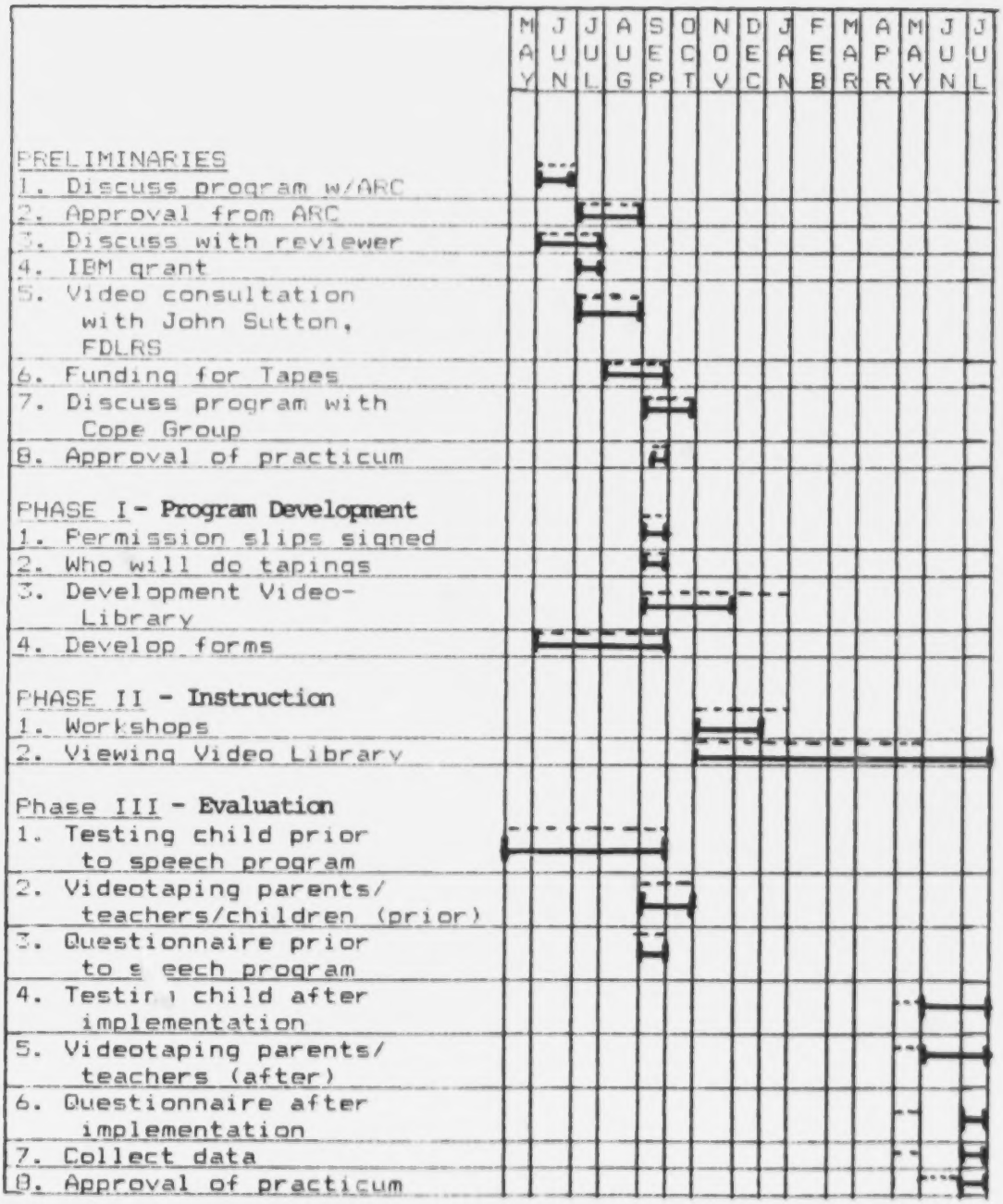
BEST COPY AVAILABLE

APPENDIX L

TIMETABLE

APPENDIX L

Timetable



Note: ——— = proposal; ----- = actual implementation

APPENDIX M

PARENTAL PERMISSION SLIP

APPENDIX M

Dear Parent,

In the fall of 1984, children will be videotaped for the purpose of developing a Speech Videotape Library. This will consist of videotaped therapy segments to help train parents and teachers to carryout the speech therapist's speech goals at home and in school. You will be welcomed to borrow the videotapes to view at home or at school. Please sign the permission slip below.

(clip and return)

I give permission for (child's name)_____to be videotaped for the development of a Speech Videotape Library to be used by myself as well as other parents and teachers.

_____
(Parent's Signature)

_____
(Date)

APPENDIX N

LETTER TO PARENTS

APPENDIX N

Letter to Parents

Dear Parents,

A Videotape Library has been developed to train parents and teachers how to review speech therapy goals for your child at home and in school. With the help of parents and teachers, your child can receive more speech therapy (5-7 days per week) than is possible with only the speech therapist.

You are welcomed to use the Videotape Library at home, at school, or any other place a videotape player is available. Please contact me and I will explain how you can take advantage of our new speech program. Thank you for your interest.

Sincerely,

Renai Jonas
Speech-Language Pathologist